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68- 8001 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8001

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>EDITH SHAMBERGER FITZELL</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>August 5, 1968</b> 5:30 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>103 Croydown Road</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 5, 1968</b> 5:30 A.M.	
6. SEX <b>Female</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>OCT. 5.1891</b>		10. AGE (In years lost birthday) <b>76</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>MARTHA J. SMITH</b>		13. FATHER'S NAME <b>DANIEL SHAMBERGER</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>213/50/8421</b>	
18. INFORMANT <b>C. EDWIN FITZELL (AS IN 5 ABOVE)</b>		ADDRESS	
19. <b>412.4</b> CAUSE OF DEATH <b>Arteriosclerotic Cardiovascular Disease</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED <b>August 5, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>CREMATION</b>		24B. DATE <b>8/5/1968</b>	
24C. NAME of CEMETERY or CREMATORY <b>GREENMOUNT</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 6 1968</b>		25B. NAME OF REGISTRAR <i>W. Brooks Bradley</i> <b>W. BROOKS BRADLEY, DUNDALK, MD.</b>	

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68- 8002 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8002

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>GEORGE M. DAVIS SR</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 2, 1968		Hour 2:40 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>CITY HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year August 2, 1968		Hour 2:40 A. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>					
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Sparrows Point</b>	
9. DATE OF BIRTH <b>8/5/24</b>		10. AGE (In years lost birthday) <b>43</b>		E. STREET AND NUMBER <b>620 "C" Street</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		13. FATHER'S NAME <b>MARTIN E. DAVIS</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECT. ENG.</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>		15. MOTHER'S MAIDEN NAME <b>CARRIE HOWE</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW II</b>		17. SOCIAL SECURITY NO. <b>219-189-230</b>		18. INFORMANT <b>ELIZABETH DAVIS</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>E814.7</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <b>Multiple Traumatic Injuries</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>53-00</b>	
20A. DATE OF OPERATION <b>8/12/68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>II</b>		21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Route 151 South of Morse Lane</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) August 2, 1968 2:05A.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Pedestrian struck by car</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>August 2, 1968</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/7/68</b>		24C. NAME of CEMETERY or CREMATORY <b>BALTO. NAT.</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 6 1968</b>		25B. NAME OF REGISTRAR <b>Ronald E. Finkbeiner</b>	
25C. FUNERAL DIRECTOR <b>J. G. CONNELLY SONS</b>		25D. ADDRESS <b>300 MACE</b>			

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WALLLEY FOPFOL

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68- 8003 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8003

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>DIRZUWEIT</b> <i>Thelma Dirzuweit</i>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 8 Day 3 Year 68 Hour 4:30 AM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>31 City Hospital</b>		3. DATE PRONOUNCED DEAD Month 8 Day 3 Year 68 Hour 4:30 AM	
6. SEX <b>F</b>		7. RACE <b>W</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Essex BALTO Co.</b>	
9. DATE OF BIRTH <b>7/12/12</b>		10. AGE (In years last birthday) <b>56</b>	
11. BIRTHPLACE (State or foreign country) <b>W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>217-03-7948</b>	
18. INFORMANT <b>ALFRED DIRZUWEIT</b>		ADDRESS <b>ABOVE</b>	
19. <b>431.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Massive spontaneous intra-cerebral hemorrhage.</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
331 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> DATE SIGNED <b>Aug. 3, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/6/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>GARDENS OF FAITH</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 6 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>	
25C. FUNERAL DIRECTOR <b>J. E. CONNELLY SONS</b>		ADDRESS <b>300 MACE</b>	

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WALLER & BROS

25% SALES TAX

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8004 BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 8004

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ARTHUR CATTERTON</b>		2. DATE AND HOUR OF DEATH <b>8/4/68 4:30 AM.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY		<b>25-04</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b> <b>BALTIMORE MD</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
5. SEX <b>MALE</b>		6. RACE <b>CAUCASIAN</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Baker</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>3/29/89</b>	
13. FATHER'S NAME <b>James B. Catterton</b>		14. MOTHER'S MAIDEN NAME <b>Mary L. Catterton</b>		9. AGE (In years last birthday) <b>80 79</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W. W. 1</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mr. James A. McKeldin</b>	
18. <b>43691</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>CV A</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>DEHYDRATION</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7/26 19 68</b> to <b>8/4 19 68</b> , that (I) (we) last saw the deceased alive on <b>8/4 19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ronald M. Legum MD</b>				23B. DATE SIGNED <b>8/4/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>RONALD M. LEGUM MD</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b> <b>UNION MEMORIAL HOSPITAL BAL MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/7/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>	
24D. LOCATION <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 6 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fairbanks</b>		25C. FUNERAL DIRECTOR <b>McCully F. H.</b>			
25D. ADDRESS <b>Balto. Md. 21225</b> <b>237 Patapsco Ave.</b>					

10/18/80

10/18/80

A S S

10/18/80

THE HOUSE MAY BE MOVED TO

10/18/80

C-434

68-8005

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

68-8005

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM T. CALDWELL

2. DATE AND HOUR OF DEATH

August 4, 1968

3:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Ave.

Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

Essex

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

236 Engleberth Road # 21221

5. SEX

Male

6. RACE

White

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

5-3-16

9. AGE (In years  
lost birthday)

52

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Builder

10B. KIND OF BUSINESS OR INDUSTRY

Home Construction

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Caldwell Dec.

14. MOTHER'S MAIDEN NAME

Henrietta Theiss

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

219 01 7975 BCH: 4940

17. INFORMANT  
Records

ADDRESS

# 21224  
Eastern Ave. Baltimore, Maryland18. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

Bronchopneumonia + Sepsis

IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Paraplegia - Thoracic Vertebra Fracture

Prolonged Hypotension

DUE TO, OR AS A CONSEQUENCE OF:

Massive Decubitus Ulcers

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

Months

2 hrs

18 years

30 hrs

1968

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Paraplegia

19A. DATE OF OPERATION

7/13/68 + 8/3/68

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

Debridement of Decubiti

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

No

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

Belair Road

00-00

21D. TIME  
OF INJURY  
(APPROX.)

1950

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☒

21F. HOW DID INJURY OCCUR?

Car slid on Ice - hit pole

22. I certify that (I) (this hospital) attended the deceased from 6-24 1968 to August 4 1968.  
that (I) (we) lost saw the deceased alive on August 4 1968 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Genevieve Mac Donald

23B. DATE SIGNED

8-4-68

23C. PHYSICIAN'S  
NAME (Type)

Genevieve Mac Donald MD.

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Ave. Baltimore, Maryland # 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8/7/68

24C. NAME OF CEMETERY OR CREMATORY

Gardens of Faith Cemetery

24D. LOCATION

Baltimore Co., Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 6 1968

25B. NAME OF REGISTRAR

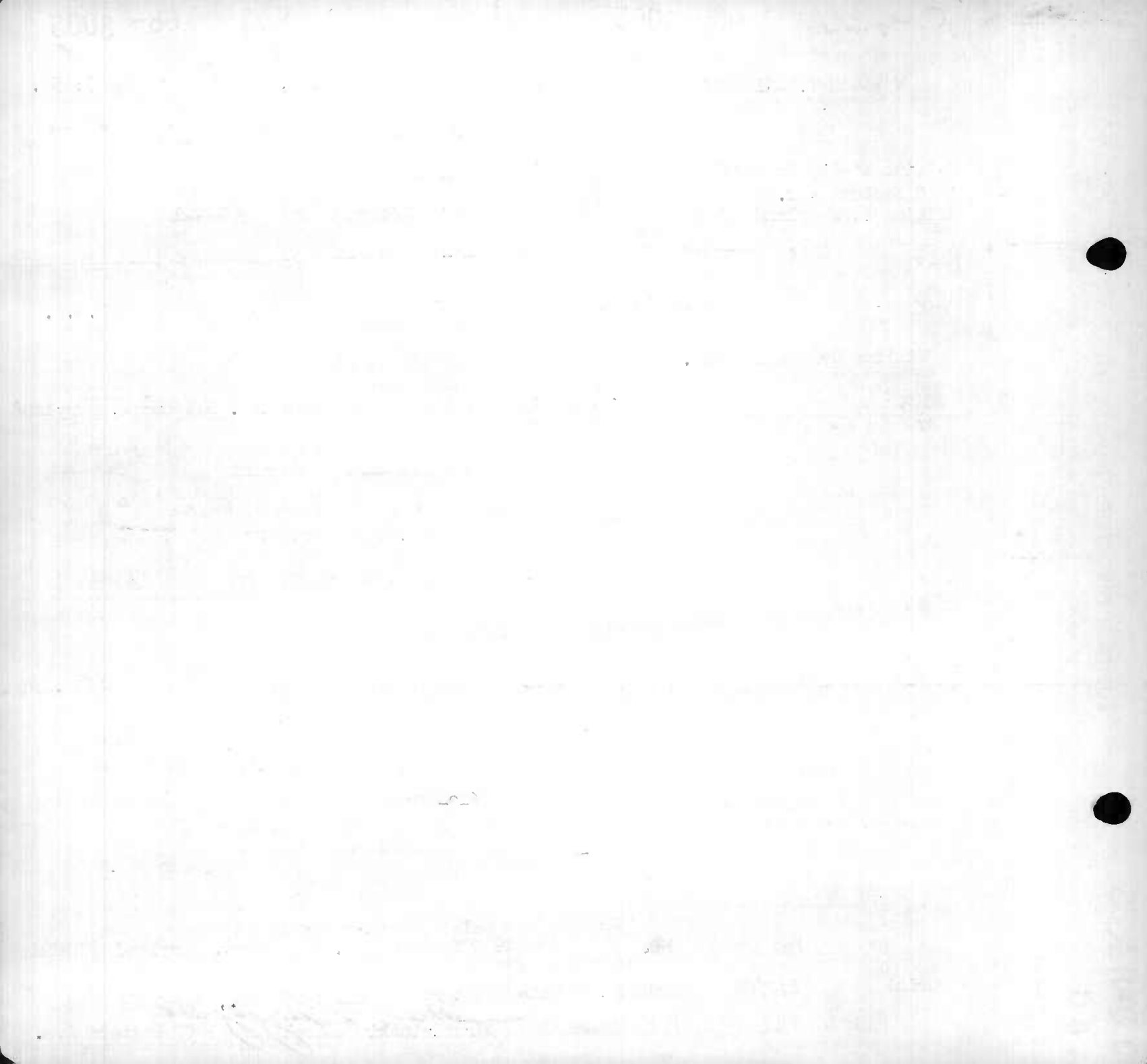
Robert E. Taylor, MD

25C. FUNERAL DIRECTOR

Bruzdzinski Funeral Home 1407 Eastern Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8006

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68- 8006

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Doole George R.

2. DATE AND HOUR OF DEATH

8-5-68

4 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Univ. of Maryland Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md. Balto.

C. CITY OR TOWN

Balto

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

704 E. 35th

5. SEX

Male

6. RACE

Cauc

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

10-26-17

9. AGE (In years  
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

PR Man

10B. KIND OF BUSINESS OR INDUSTRY

Public Relations # Md.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Poole

14. MOTHER'S MAIDEN NAME

Lillian Mitter

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

WW II

16. SOCIAL  
SECURITY NO.

213-16-0553

17. INFORMANT

Wife

ADDRESS

Frances A. Poole Same as above

18. 5-21-91

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

Acute Renal Failure

3 days

(B) Progressive Hepatic Failure  
DUE TO, OR AS A CONSEQUENCE OF:

Progressive Hepatic Failure

11 weeks

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A)

Cirrhosis of Liver

19A. DATE OF OPERATION

3/7/1968

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐

Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-27 19 68 to 8-5 19 68.

that (I) (we) last saw the deceased alive on 8-5 19 68 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Shoo-Huang Chiu

M.D.  
DEGREE

Attending  
Phys. ☐

Med.  
Director ☐

Staff  
Phys. ☒

23B. DATE SIGNED

8-5-68

23C. PHYSICIAN'S  
NAME (Type)

Shoo-Huang Chiu

DEGREE

23D. ADDRESS

Univ. of Maryland Hospital Balto. Md.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8-9-1968

24C. NAME OF CEMETERY or CREMATORY

Balto Nat'l. Cem.

24D. LOCATION

Balto. Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 6 1968

25B. NAME OF REGISTRAR

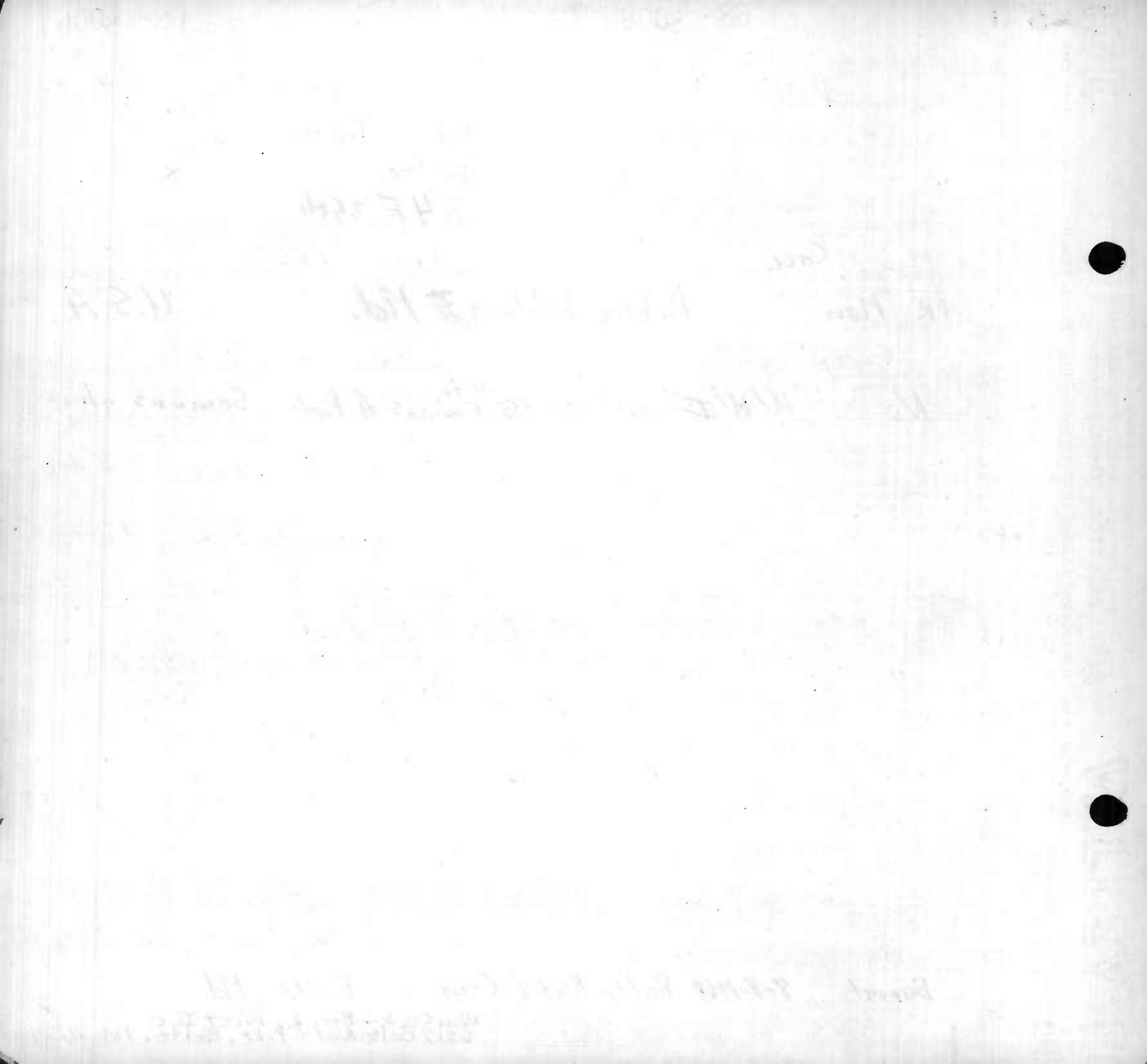
Robert E. Johnson

25C. FUNERAL DIRECTOR

Wm Cook - Brooks West Inc.

ADDRESS

6212 Balto Nat'l. Pike, Balto. Md. 21229



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-8007
BIRTH NO.		68-8007		
1. NAME OF DECEASED (Type or Print) <b>CHARLES SMITH</b>		2. DATE AND HOUR OF DEATH <b>8-4-68 12:15 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>A.A.C.</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Boiton Hill Nursing Center</b>		C. CITY OR TOWN <b>SEVERNA PARK</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>994 Bayberry</b>		
5. SEX <b>W M</b>	6. RACE <b>M</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-7-1893</b>	9. AGE (In years last birthday) <b>74</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Oil Business</b>		11. BIRTHPLACE (State or foreign country) <b>Fort Worth Texas</b>
				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Charles L. Smith Sr.</b>		14. MOTHER'S MAIDEN NAME <b>11-7-1893</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>462-38-9886B</b>		17. INFORMANT <b>Admission Record</b>
18. <b>433.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Thrombosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral Arteriosclerosis</b>		
		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Unknown</b>		
		(C) _____		
19. <b>332 X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>*ASHD Multiple deg. joint disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Several years</b>		
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>NO</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>June 10, 1968</b> to <b>Aug 4, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 3, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Roland T. Smoot, M.D.</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>8/4/68</b>
23C. PHYSICIAN'S NAME (Type) <b>ROLAND T. SMOOT, M.D.</b>		23D. ADDRESS <b>3817 CUDLEY RD., BALTO. 15, MD</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>	24B. DATE <b>8-5-1968</b>	24C. NAME OF CEMETERY or CREMATORY <b>Marshall + Marshall</b>	24D. LOCATION (City, town, or county) (State) <b>Hillsboro, Texas</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 6 1968</b>	25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>	25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks, Inc. Balto. Md</b>		

213

CLARK & SONS  
No. 1

Wm. L. Clark & Sons, Inc.  
213

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 8008 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 8008

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SUE LEE GIVEN		August 3, 1968 11 <sup>20</sup> P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
Edgewood Nursing Home 6000 Bellona Ave. Baltimore, Maryland				Maryland Baltimore 53-00	
				C. CITY OR TOWN Sparks	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER Sparks Road	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)
Female	Cau.	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov. 13, 1891		76 Yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Homemaker		Home		Maryland	
13. FATHER'S NAME Joshua H. Cockey			14. MOTHER'S MAIDEN NAME Annie Hutchins		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
no			220-46-2571		Cecil A. Giveh, 10 Belclare Circle, 21152
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>ARTERIO-SCLEROTIC HEART DISEASE</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) _____ DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> </div> </div>					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>420.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> </div> <div style="width: 50%;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from SEPT 1966 to AUG 3 1968, that (I) (we) last saw the deceased alive on AUG 3 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE T. C. Siwinski				23B. DATE SIGNED 5 AUG 68	
23C. PHYSICIAN'S NAME (Type) Thaddeus C. Siwinski, M.D.				23D. ADDRESS 206 E. Penna. Ave., Towson, Md. 21204	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8-7-1968		St. James' Episcopal	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 6 1968		Robert E. Fulkerson		Wm. Cook-Brooks Towson, 1050 York Rd. Towson, Maryland	



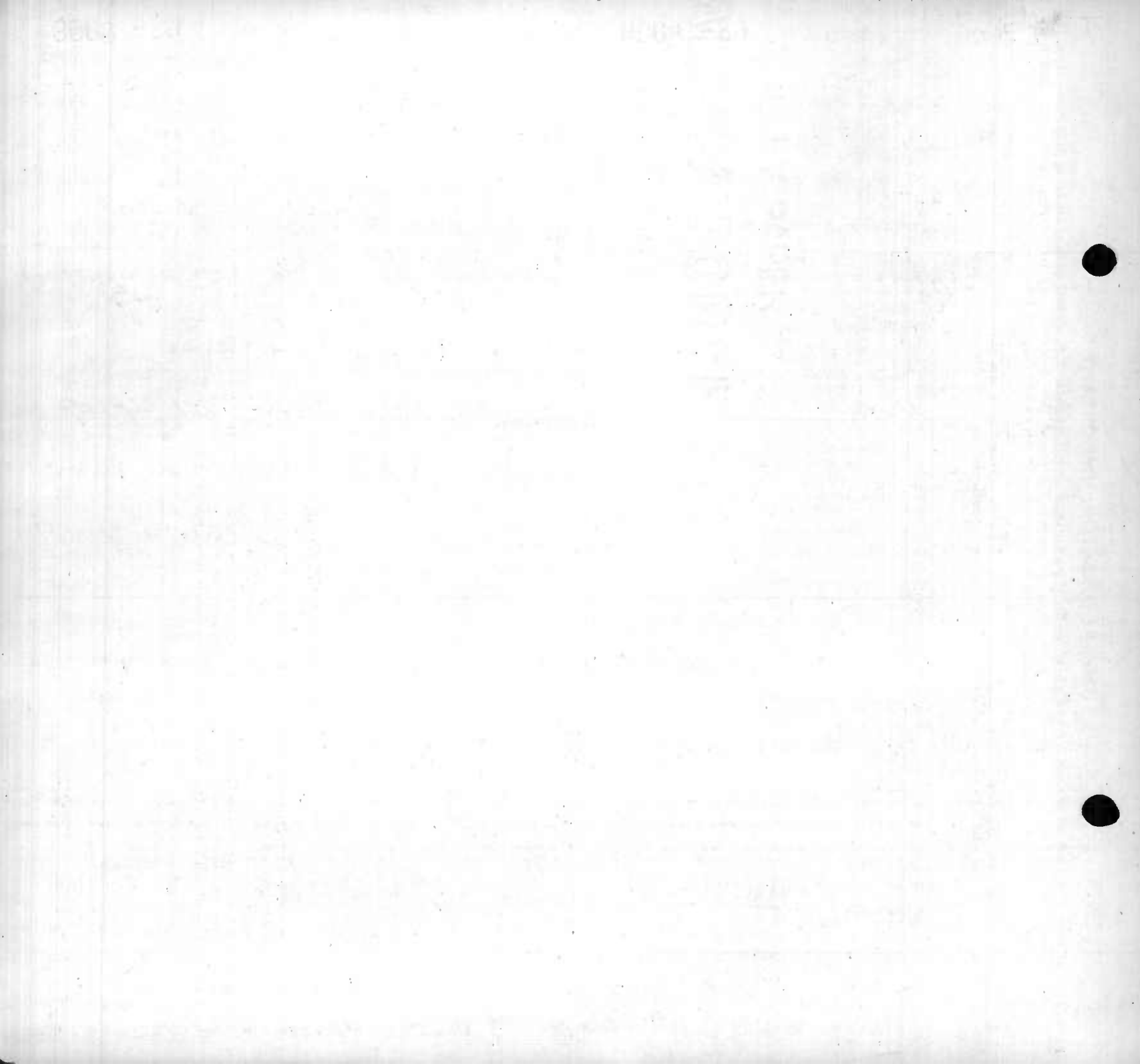
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 68- 8009 CERTIFICATE OF DEATH

REG. NO. 68- 8009

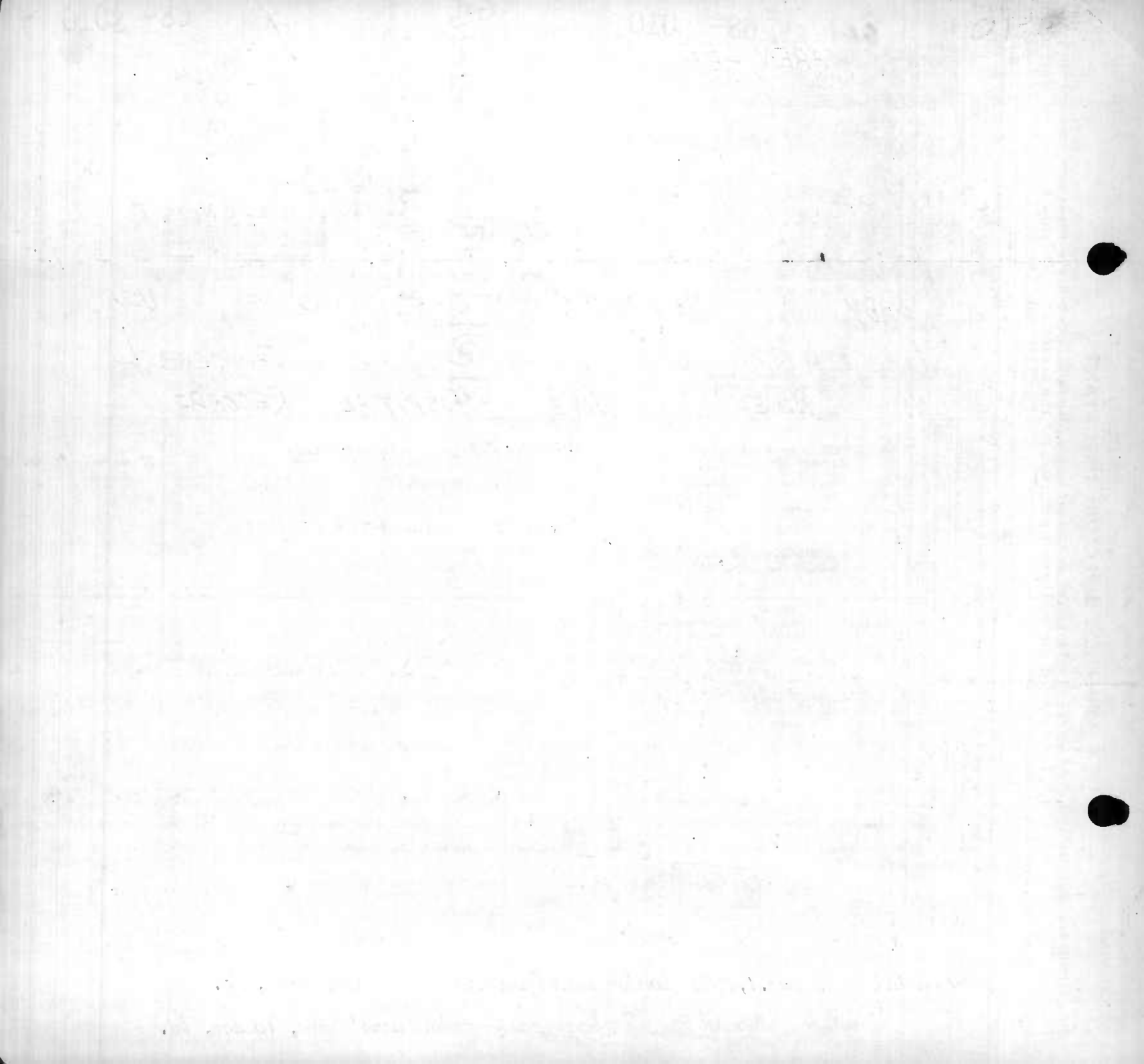
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>TRAUT, ALBERT</b>		2. DATE AND HOUR OF DEATH <b>8-2-1968</b> <b>2-A-M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-01</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME HOSPITAL</b> <b>35</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>4711 SCHLEY AVE 21206</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-24-03</b>	9. AGE (In years last birthday) <b>64</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>APPLIANCE SERVICEMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>CONRAD TRAUT</b>			14. MOTHER'S MAIDEN NAME <b>LOUISE WHITGRAF</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-05-3163</b>		17. INFORMANT <b>MRS RAYNA BIGGS-4711 SCHLEY AV</b>	
18. <b>412.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE PULMONARY EDEMA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>443X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>443X II</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Pulmonary edema</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertension and Arterio-sclerotic heart disease</b> (C) _____		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <b>N</b> (this hospital) attended the deceased from <b>8-1-1968</b> to <b>8-2-1968</b> , that <b>N</b> (we) last saw the deceased alive on <b>8-2-1968</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <b>J. Nidiry</b>			23B. DATE SIGNED <b>8-2-1968</b>		23C. PHYSICIAN'S NAME (Type) <b>JOSEPH NIDIRY M.D.</b>
23D. ADDRESS <b>CHURCH HOME AND HOSPITAL</b>			23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/5/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTIMORE CEMETERY</b>	
24D. LOCATION <b>BALTIMORE MD</b>		24E. DATE REC'D BY HEALTH DEPT. <b>AUG 6 1968</b>			
24F. NAME OF REGISTRAR <b>Robert E. Jackson</b>		24G. FUNERAL DIRECTOR <b>OLLIEK FUNERAL HOME-4210 BELT RD</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
REG. NO. 68-8010 7									
BIRTH NO. 68-14541 68-8010					CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) <b>KAREN LEE BABY CARRELL</b>					2. DATE AND HOUR OF DEATH <b>July 30, 1968 - 1245 PM</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hospital.</b>					A. STATE <b>Md.</b>		B. COUNTY <b>Balto Co 53.00</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN <b>Cockeysville</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
					E. STREET AND NUMBER <b>602 Knollcrest Place</b>				
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/30/68</b>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: <b>5 15</b>		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BABY</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NEW BORN</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>RICHARD W. CARRELL</b>				14. MOTHER'S MAIDEN NAME <b>SUSAN STENGEL</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO NONE</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT ADDRESS <b>HOSPITAL RECORDS</b>			
18. <b>776.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>RESPIRATORY DISTRESS</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>at birth to death</b>				
19. <b>773.5 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>July 30, 1968 730 AM</b> to <b>July 30, 1968 1245 PM</b> , that (I) (we) lost saw the deceased alive on <b>July 30, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Arturo Q. Santos, M.D.</b>				23B. DATE SIGNED <b>July 30, 1968</b>					
23C. PHYSICIAN'S NAME (Type) <b>ARTURO Q. SANTOS, M.D.</b>				23D. ADDRESS <b>MERCY HOSPITAL 301 St Paul Place Balto Md 21202</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug 1, 1968</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 6 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Md.</b>				ADDRESS	



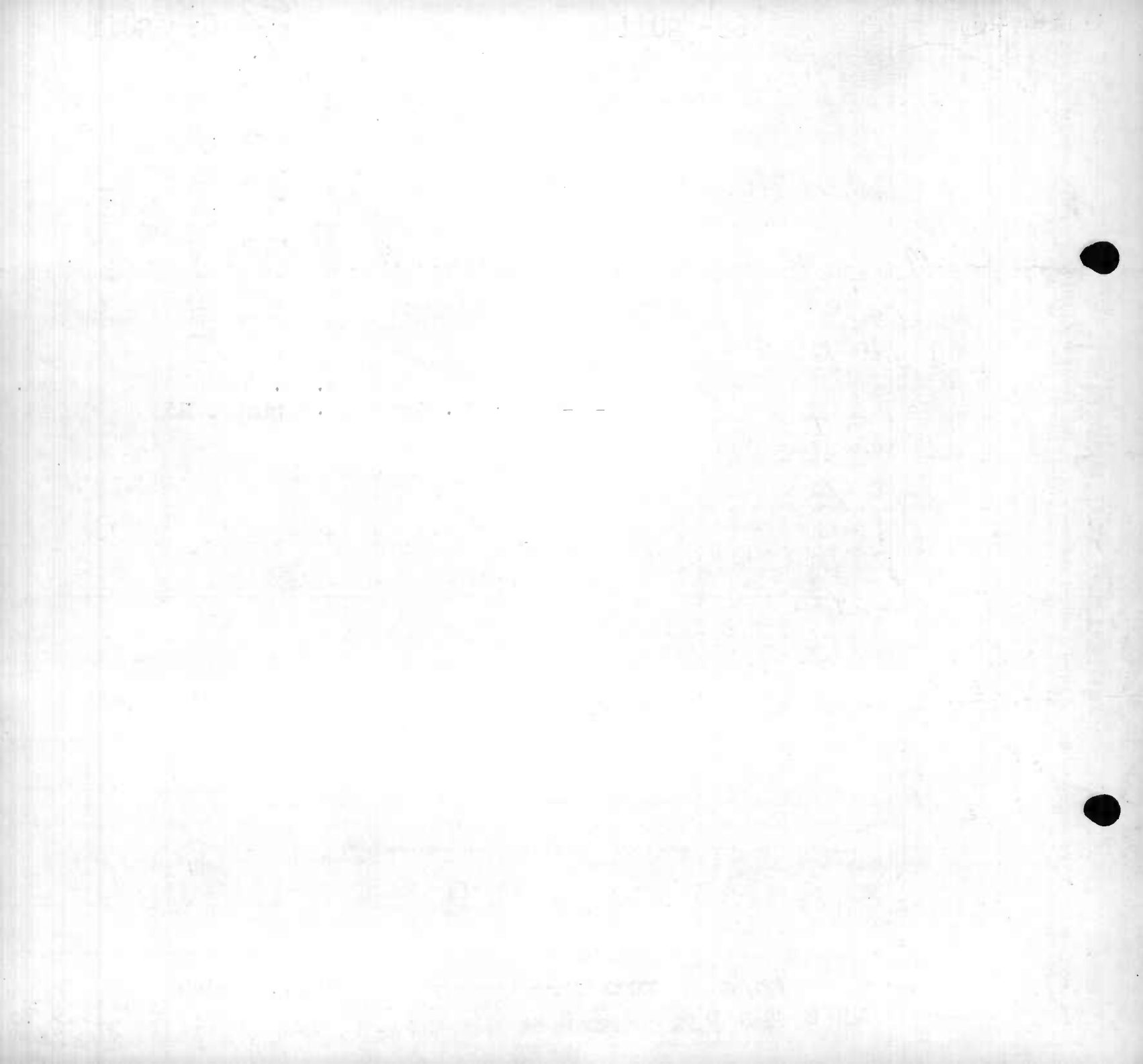
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 68- 8011 CERTIFICATE OF DEATH

REG. NO. 68- 8011

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MERICA DEWEY</b>		2. DATE AND HOUR OF DEATH <b>Aug. 3 1968 10 45</b> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>4.4.10</b>		C. CITY OR TOWN <b>Anundel</b> D. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>#3 South Baltimore General Hosp</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>6315 Arundel Cove Ave. #26</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/26/19</b>	9. AGE (In years lost birthday) <b>69</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Chemical Operator</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S. citizen</b>		13. FATHER'S NAME <b>Dewitt Merica</b>		14. MOTHER'S MAIDEN NAME <b>Arbellie Cubegge</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-07-7951</b>		17. INFORMANT <b>Balto. Md. 21226</b> <b>Mr. Glenwood F. Merica</b> ADDRESS <b>6315 Arundel Cove Ave.</b>	
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ASCVD</b> (B) <b>Cerebral Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Pneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10-20 yrs</b> <b>10 days</b> <b>5 days</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>422.1 II</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>S. R. Gehlert, Jr. M.D.</b>		23B. DATE SIGNED <b>8/3/68</b>		23C. PHYSICIAN'S NAME (Type) <b>S. R. Gehlert, Jr. M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/7/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Elkrun Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Elkton, Virginia</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 6 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Faldut</b>	
25C. FUNERAL DIRECTOR <b>McCallum</b>		25D. ADDRESS <b>237 Palapasco</b>		25E. ADDRESS <b>21225</b>	



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## CERTIFICATE OF DEATH

REG. NO.

68-8012

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Roy Andrew Walker

2. DATE AND HOUR OF DEATH

Aug. 2, 1968

5 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)US Public Health Service Hospital  
3100 Wyman Pk. Drive

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Va.

C. CITY OR TOWN

Virginia Beach

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

907 Maryland Ave.

5. SEX

M

6. RACE

W

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

12/16/06

9. AGE (In years  
last birthday)

61

If Under 1 Yr.

Months: Days:

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Stockman

10B. KIND OF BUSINESS OR INDUSTRY

Ford Motor Co.

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Herbert Walker

14. MOTHER'S MAIDEN NAME

Bertha Harrison

15. Was Deceased Ever in U. S. Armed Forces?

No

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

231-10-8676

17. INFORMANT

ADDRESS

Records- US PHS Hospital, Balto, Md.

18.

146.0 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Exsanguination  
Rupture of left internal  
carotid artery

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

Epidermoid carcinoma of the  
left tonsilAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

Terminal

Terminal

2 1/2 yrs

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At

Work ☐

Not While

At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 1 19 68 to Aug. 2 19 68,  
that (I) (we) last saw the deceased alive on Aug. 2 19 68 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Henry S. Crist, MD

DEGREE

Attending ☐  
Phys.Med. ☐  
DirectorStaff ☒  
Phys.

23B. DATE SIGNED

8/2/68

23C. PHYSICIAN'S  
NAME (Type)

Henry S. Crist, Surgeon (R)

DEGREE

23D. ADDRESS

US PHS Hospital, Balto, Md.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

24B. DATE

8-2-68

24C. NAME of CEMETERY or CREMATORY

Rosewood Memorial Park

24D. LOCATION

(City, town, or county)

(State)

Virginia Beach, Va.

25A. DATE REC'D BY HEALTH DEPT.

AUG 6 1968

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Farlex Cavanaugh, Catonsville Md.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8013

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 8013

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HARNET Bookoff</b>		2. DATE AND HOUR OF DEATH <b>3 August 1968 4:40 PM</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital of Baltimore</b> <b>42</b>		E. STREET AND NUMBER <b>3704 Glensyle Ave</b>		F. STREET AND NUMBER <b>27-20</b>	
5. SEX <b>M</b>	6. RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/25/13</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Abraham</b>		14. MOTHER'S MAIDEN NAME <b>Lena</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-12-8341</b>		17. INFORMANT <b>Mrs Alma Bookoff</b> ADDRESS <b>3704 Glensyle Ave</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Accelerated Myocardial Infarct - Approx 7 hrs.</b>		19. <b>420.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A): <b>Arteriosclerotic Cardio Vaso. Disease</b> <b>Chronic Congestive Failure</b> <b>(Post Myocard. Infarct Status)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Approx. 2 yrs.</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1965</b> to <b>8-3-</b> <b>1968</b> , that (I) (we) last saw the deceased alive on <b>July</b> <b>1968</b> and that in (my) (our) opinion death occurred on the date <b>4:40 PM</b> and hour and from the causes stated above. (I) (We) did (did not) view the body after death.					
23A. SIGNATURE <b>Joseph Deckerbaum</b>		23B. DATE SIGNED <b>8-3-68</b>		23C. PHYSICIAN'S NAME (Type) <b>JOSEPH DECKERBAUM, M.D.</b>	
23D. ADDRESS <b>3502 WEST ROGERS AVE. BALTO. 2215</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/4/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Bnai Israel</b>		24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 6 1968</b>	
25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Sylvan S. Lewis &amp; Son</b>		ADDRESS <b>9610 Rustenburg Rd</b>	

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FUNERAL DIRECTOR: IMPORTANT

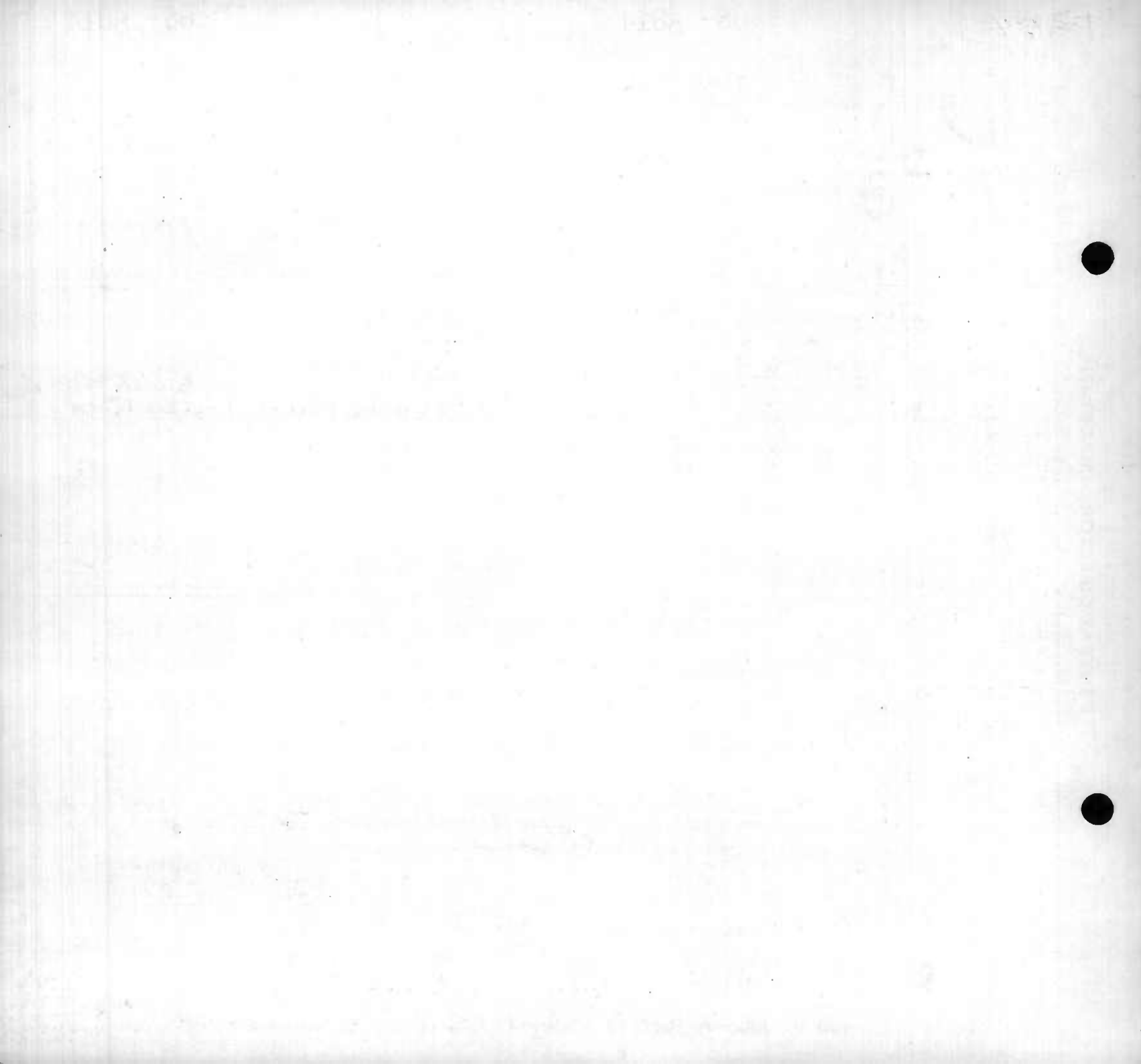
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8014

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 8014

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>IDA TERLITSKY</b>		2. DATE AND HOUR OF DEATH <b>8-2-68</b> <b>5 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>27-20</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAI HOSP - BALTIMORE, MD.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTO</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>7015 FIELDCREST RD</b>					
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-15-88</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Caterer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Food</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Morris</b>		14. MOTHER'S MAIDEN NAME <b>Toba</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-20-6397D</b>		17. INFORMANT <b>MRS DORA MILLMAN 8524 16<sup>th</sup> ST</b>	
18. <b>199.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CA - undifferentiated with metastases ~ 1-1 1/2 yrs.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
199.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A.</b>		20A. AUTOPSY? (Yes or No) <b>Yes.</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>N/A.</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>this hospital</del> attended the deceased from <b>7-11 19 68</b> to <b>8/2 19 68</b> , that <del>we</del> <b>we</b> last saw the deceased alive on <b>7/2 19 68</b> and that in <del>our</del> <b>our</b> opinion death occurred on the date and hour and from the causes stated above. <del>We</del> <b>We</b> <del>did not</del> <b>did not</b> view the body after death.					
23A. SIGNATURE <b>Norman B. Rosen, MD</b>		23B. DATE SIGNED <b>8-2-68</b>		23C. PHYSICIAN'S NAME (Type) <b>NORMAN B. ROSEN, MD</b>	
23D. ADDRESS <b>SINAI HOSP - BALTIMORE, MD</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/4/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Hebrew Friendship Balto</b>	
24D. LOCATION (City, town, or county) <b>MD</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 6 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Tarkenton</b>		25C. FUNERAL DIRECTOR <b>Sylvan S. Lewis &amp; Son, Inc</b>	
ADDRESS <b>9610 Reisterstown</b>					



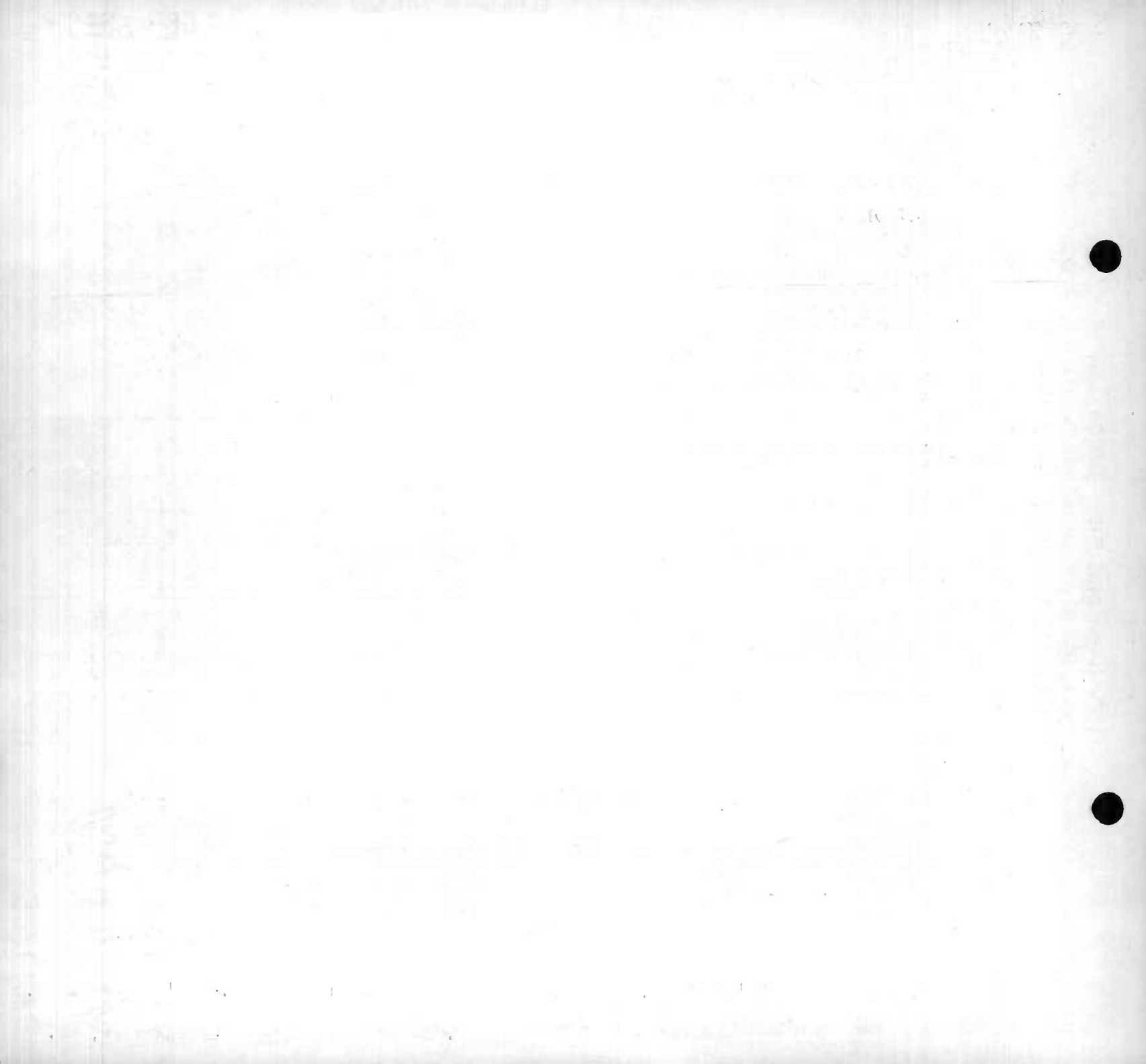
FUNERAL DIRECTOR: IMPORTANT

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68- 8015 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 8015

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WALTER BUTLER</b>		2. DATE AND HOUR OF DEATH <b>30 July 68 125 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Anne Arundel 52-00</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIV. OF Md Hosp 38</b>				C. CITY OR TOWN <b>Gambills</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>P.O. Box 86</b>	
5. SEX <b>M</b>	6. RACE <b>Neg</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/14/66</b>	9. AGE (In years lost birthday) <b>6</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabner</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Alfred Butler</b>	
14. MOTHER'S MAIDEN NAME <b>Madelina Butler</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>unk</b>	
16. SOCIAL SECURITY NO. <b>—</b>				17. INFORMANT <b>old chart</b> ADDRESS	
18. <b>410.0 I</b> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			Cardiac arrest		
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Possible MI 2°		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>To Hypertension</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>420.1 II</b>					
19A. DATE OF OPERATION <b>D</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>30 July 1968</b> to <b>30 July 1968</b> , that (I) (we) last saw the deceased alive on <b>30 July 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Stanley Music M.D.</b> DEGREE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>STANLEY MUSIC M.D.</b> DEGREE				23D. ADDRESS <b>96 Univ of Md Hosp</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/3/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>ST. PETER CLAVERS</b>	
24D. LOCATION (City, town, or county) <b>RIDGE</b>		(State) <b>ST. MARY'S</b>		<b>MARYLAND.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 6 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Tarkenton</b>		25C. FUNERAL DIRECTOR ADDRESS <b>W. CLARKE MATTINGLEY LEONARDTOWN, MD.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>68- 8016</b>	
BIRTH NO. <b>68- 8016</b>				1968	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH <b>Aug. 3rd 9:40 A.M.</b>	
1. NAME OF DECEASED (Type or Print) <b>JAMES MAGNESS Sr.</b>				3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
<div style="font-size: 2em; font-weight: bold;">CERTIFICATE AMENDED</div>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
				A. STATE <b>Md.</b> B. COUNTY <b>12-07</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>8-9-68</b> <b>UNION MEMORIAL HOSPITAL BALT. MD.</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
				D. STREET ADDRESS (If rural, give location) <b>2634 Hampden Avenue 21211</b>	
5. SEX <b>M</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b>	8. DATE OF BIRTH <b>11/1/21</b>		9. AGE (In years last birthday) <b>46</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Horse Shoer</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Stephen Magness</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Np</b>			16. SOCIAL SECURITY NO. <b>212-16-6212A</b>		17. INFORMANT <b>James A. Magness Jr. 2634 Hampden Avenue</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Emboli, Massive</b>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTERIOSCLEROSIS Heart Disease</b>			C.S.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>420.0 II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/3 7:31 1968</b> to <b>8/3 1968</b> , that (I) (we) last saw the deceased alive on <b>8/3 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ronald M. Legum</b>				23B. DATE SIGNED <b>8/3/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>M.D.</b>				23D. ADDRESS <b>UNION MEMORIAL HOSPITAL BALT. MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-6-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore Co.</b>		24E. STATE <b>Md.</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 6 1968</b>	
25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>7401 Belvoir Rd.</b>		25D. ADDRESS	

UNION MEMORIAL HOSPITAL  
BAPT. MD  
M. GARCIA  
MARRIED

11/1/71  
MD

USA

Hand M. Garcia  
OO

UNION MEMORIAL HOSPITAL BAPT. MD

8/1/78

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8017 CERTIFICATE OF DEATH

REG. NO. 68- 8017

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Margaret I. Novotny</i>		2. DATE AND HOUR OF DEATH <i>August 2, 1968</i> <i>8 A.</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>26-03</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>00 3106 Chesterfield Avenue</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>3106 Chesterfield Ave.</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 24, 1898</i>	9. AGE (In years last birthday) <i>70</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John Holzschuh</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Koenig</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>William H. Novotny - 3106 Chesterfield Ave.</i>	
18. <i>019.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Bullous emphysema, severe</i> (B) <i>Pulmonary tuberculosis (arrested)</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. <i>002.2 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<i>Arteriosclerotic heart disease</i>			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Feb. 23, 1968</i> to <i>July 9, 1968</i> , that (I) (we) last saw the deceased alive on <i>July 9, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>B. Moley</i>		23B. DATE SIGNED <i>8/2/68</i>			
23C. PHYSICIAN'S NAME (Type) <i>BENIGNO M. OTEYZA</i>		23D. ADDRESS <i>1012 OLD NORTH POINT RD. BALTIMORE, MARYLAND</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-6-68</i>		24C. NAME of CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Md. -21206</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 6 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, MA</i>	
25C. FUNERAL DIRECTOR <i>John C. Miller Inc.</i>		25D. ADDRESS <i>-6415 Belair Rd.</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8018

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68- 8018

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HUBER, JOHN EDWARD

2. DATE AND HOUR OF DEATH

Aug. 1, '68 8:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

35 FRANKLIN SQUARE Hosp.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE 8. COUNTY

MARYLAND.

C. CITY OR TOWN

BALTIMORE

E. STREET AND NUMBER

480 S. BENTALON ST. 21223.

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

5. SEX

M

6. RACE

W.

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

3/4/194

9. AGE (In years  
last birthday)

74

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

RETIRED.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

JOHN HUBER

14. MOTHER'S MAIDEN NAME

~~XXXXXXXXXXXXXXXXXXXX~~ Mary Schmidt

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

705052081

17. INFORMANT

ELLA HUBER. 480 S. BENTALON ST.

ADDRESS

18. 347.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

Cardiac Arrest

(B) Central Nervous System Degeneration

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

355 X II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At ☐ Not While  
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/22/68. 19 8 to 8/1 19 68.  
that (I) (we) last saw the deceased alive on 8/1 19 68 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Charles Du Kwon

Attending  
Phys.

Med.  
Director

Staff  
Phys.

23B. DATE SIGNED

8/1/68.

23C. PHYSICIAN'S  
NAME (Type)

Charles Du Kwon

23D. ADDRESS

FRANKLIN SQUARE Hosp.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8-5-1968

24C. NAME of CEMETERY or CREMATORY

Meadowridge Cemetery

24D. LOCATION

(City, town, or county)

Howard County, Maryland

(State)

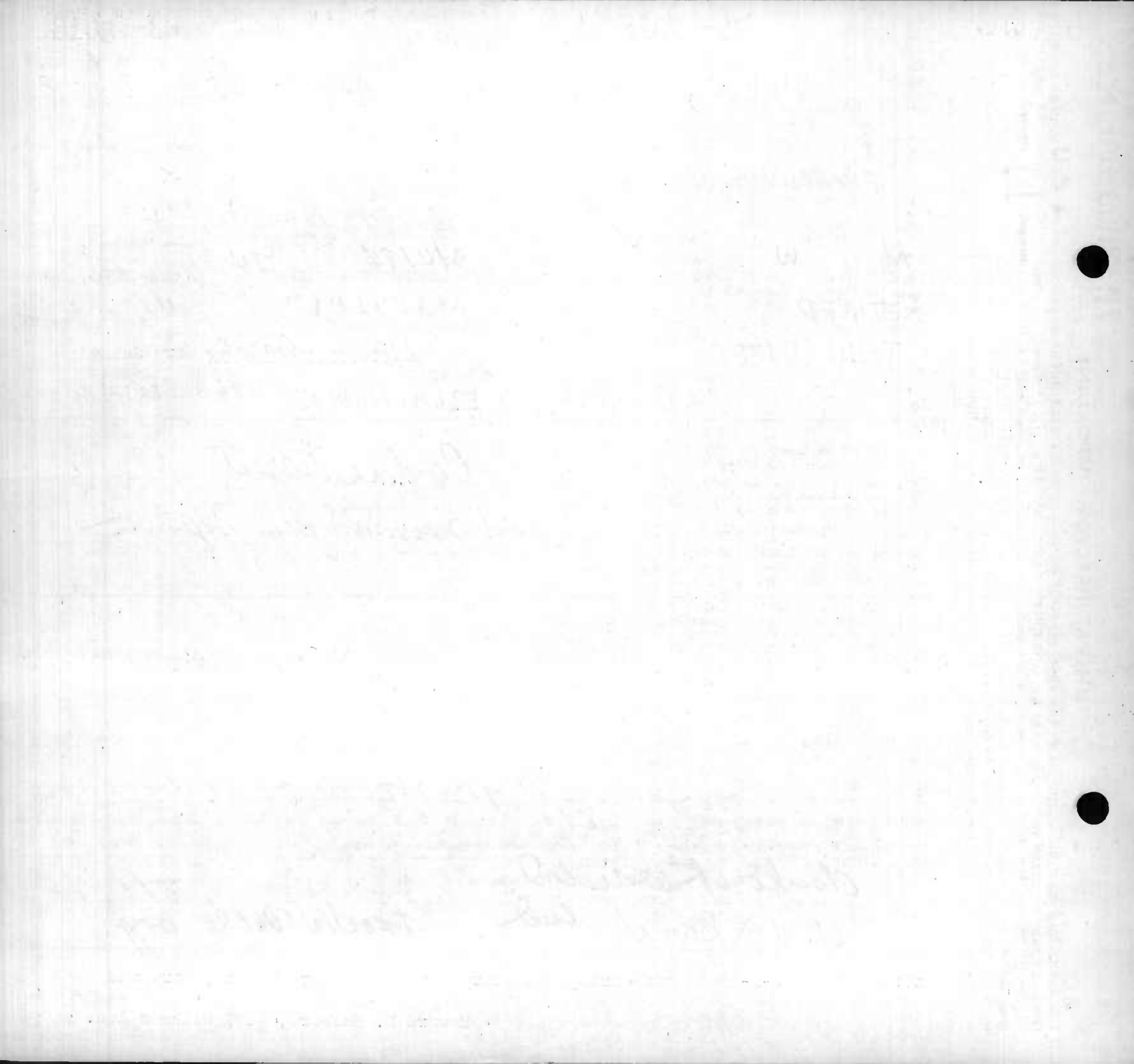
25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Howard H. Hubbard, 4107 Wilkens Ave. 21229



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>A-153</b>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>68-8019</b>
1. NAME OF DECEASED (Type or Print) <b>OLYMPIA ABENDSCHEIN</b>		2. DATE AND HOUR OF DEATH <b>8-2-68</b> <b>4:00 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>26-11</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b>		C. CITY OR TOWN <b>BALTIMORE</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
4940 EASTERN AVENUE BALTIMORE, MARYLAND		E. STREET AND NUMBER <b>1101 S. CLINTON ST 21224</b>		
5. SEX <b>F</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-18-98</b>	9. AGE (In years last birthday) <b>70</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Crown Cork &amp; Seal</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>GEORGE</b>		14. MOTHER'S MAIDEN NAME <b>LOUISA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-108412</b>		17. INFORMANT ADDRESS <b>RECORDS: BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE #21224</b>
18. <b>153.8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CARCINOMA OF COLON</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>1 YR.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
153.8 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>7-1-68</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>BOWEL OBST</b>	20A. AUTOPSY? (Yes or No) <b>NO</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>6-20-68</b> to <b>8-2-68</b> , that (I) (we) last saw the deceased alive on <b>8-2-68</b> and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>William E. Powers, Jr. M.D.</b>		23B. DATE SIGNED <b>8-2-1968</b>		23C. PHYSICIAN'S NAME (Type) <b>WILLIAM E. POWERS, JR. MD</b>
23D. ADDRESS <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE #21224</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8-5-68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mt. Carmel</b>	24D. LOCATION <b>Balto</b>	(City, town, or county) (State) <b>MD</b>
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 6 1968</b>	25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>	25C. FUNERAL DIRECTOR <b>Thelma D. Hoffmann</b> ADDRESS <b>3218 Hudson St</b>		



1  
J-162

68- 8020 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 8020

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARY

F. JEFFERSON

2. DATE  
OF  
DEATH

Known ☐ Estimated ☐

Month Day Year  
August 5, 1968

Hour  
9:45 A. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

003302 Clifton Avenue (DOA)

3. DATE  
PRONOUNCED DEAD

Month Day Year  
August 5, 1968

Hour  
9:45 A. M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX

Female

7. RACE

Negro

B. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

8-11-1910

10. AGE (In years last birthday)

57 40

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

3302 Clifton Avenue

11. BIRTHPLACE (State or foreign country)

YOUNGSTOWN OHIO

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Frederick Jefferson

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Reg. Nurse

14B. KIND OF BUSINESS OR INDUSTRY

State of Maryland

15. MOTHER'S MAIDEN NAME

Mary Simms

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

219-36-2185

18. INFORMANT

Frederick Jefferson Harrisburg Pa.

ADDRESS

19.

5-19-2

CAUSE OF DEATH

Chronic Lung Disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

5-27-2 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 5, 1968

24A. BURIAL CREMATION, REMOVAL (Specify)

Removal

24B. DATE

8/6/68

24C. NAME of CEMETERY or CREMATORY

Lincoln

24D. LOCATION (City, town, or county) (State)

Ponchartraine Pa.

25A. DATE REC'D BY HEALTH DEPT.

AUG 6 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Marshall P. Hays 638 N. Krummer St

ADDRESS

Frederick Jefferson Harrisburg Pa.

0508-80

US08-80

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8021 CERTIFICATE OF DEATH

REG. NO. 68- 8021

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Edmund M. Schiemer

2. DATE AND HOUR OF DEATH

August 3, 1968

11 35 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

44

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

Baltimore

53-00

C. CITY OR TOWN

Hebbville

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

Salem Road Hebbville, Maryland

5. SEX

Male

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

8-18-1892

9. AGE (In years  
lost birthday)

75 yrs.

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Detroit, Michigan

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Jacob Schiemer

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

127-10-0685

17. INFORMANT

ADDRESS

Owen D. Schiemer-3309 Collier Rd. Adelphi,

18. 410.9 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET OF DEATH

1 hour

MEDICAL CERTIFICATION

420.1 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐  
WorkNot While ☐  
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/10, 1943 to 8/3, 1968,  
that (I) (we) lost saw the deceased alive on 6/14, 1968 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Robert A. Reiter, M.D.

Attending ☒  
Phys.Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

8/5/68

23C. PHYSICIAN'S  
NAME (Type)

Robert A. Reiter

23D. ADDRESS

606 Edmondson Ave

Baltimore Md. 21228

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8-7-68

24C. NAME OF CEMETERY or CREMATORY

Woodlawn Cemetery

24D. LOCATION

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 6 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Ellsworth Armacost-4600 Liberty Hghts. Ave

ADDRESS

1963-64

1963-64

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

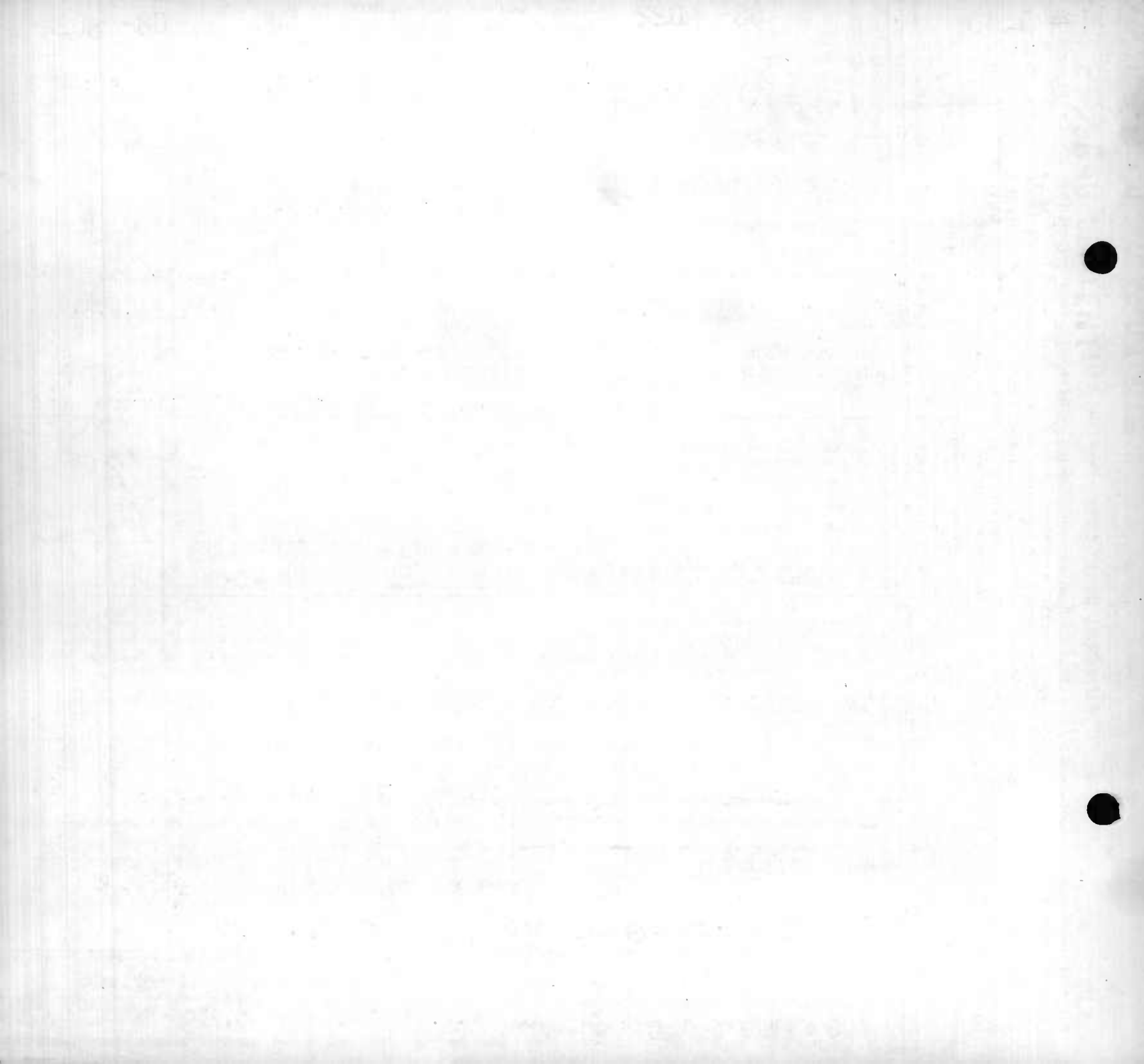
68- 8022

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 8022

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		FRANK J. HOPPER		August 3, 1968. 10:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  00 2008 Gough Street				A. STATE Maryland	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2008 Gough Street	
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/17/1904	9. AGE (In years last birthday) 63
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paperhanger		10B. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Thomas Hopa				14. MOTHER'S MAIDEN NAME Frances Milecka	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No -		16. SOCIAL SECURITY NO. 218-01-4957		17. INFORMANT Mr. Frank T. Hopper, 1830 Dunmere Road	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osphenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Carcinoma of stomach with Metastasis</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from July 30 1968 to Aug. 3 1968, that (I) (we) last saw the deceased alive on Aug. 2 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>I. J. Feinglos</i>				23B. DATE SIGNED 8/5/68	
23C. PHYSICIAN'S NAME (Type) I. J. FEINGLOS, MD				23D. ADDRESS 2008 E. Pratt St	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/68		24C. NAME OF CEMETERY or CREMATORY Holy Rosary	
24D. LOCATION Baltimore, Maryland		24E. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE			
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1968		25B. NAME OF REGISTRAR Robert E. Taylor, MA		25C. FUNERAL DIRECTOR ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. **68-8023**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MABLE BECRAFT</b>		2. DATE AND HOUR OF DEATH <b>8-4-68</b> <b>8:05</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Bolton Hill Nursing Home</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>2668 FREDERICK AVE</b>					
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-21-91</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>--- Biddle</b>			14. MOTHER'S MAIDEN NAME <b>ANNIE BROWN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-12-5819</b>		17. INFORMANT ADDRESS <b>Admission Record</b>	
18. <b>43391</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Ante Cerebral Thrombosis</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral Arteriosclerosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 day</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Myeloblastosis</b>		<b>Unknown</b>
(C) _____					
19A. DATE OF OPERATION <b>332X II</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Acute Myeloblastosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 7</b> 19 <b>68</b> to <b>Aug 4</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Aug 4</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Roland T. Smoot, M.D.</b>			23B. DATE SIGNED <b>8/4/68</b>		
23C. PHYSICIAN'S NAME (Type) <b>ROLAND T. SMOOT, M.D.</b>			23D. ADDRESS <b>3817 COPLEY RD., BALTO. 15, MD</b>		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <b>8-7-68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Crestlawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Marriottsville, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 6 1968</b>		25B. NAME OF REGISTRAR <b>R. T. Smoot</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Witzke Fun. Dir., 4101 Edmondson Ave. Baltimore, Md</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

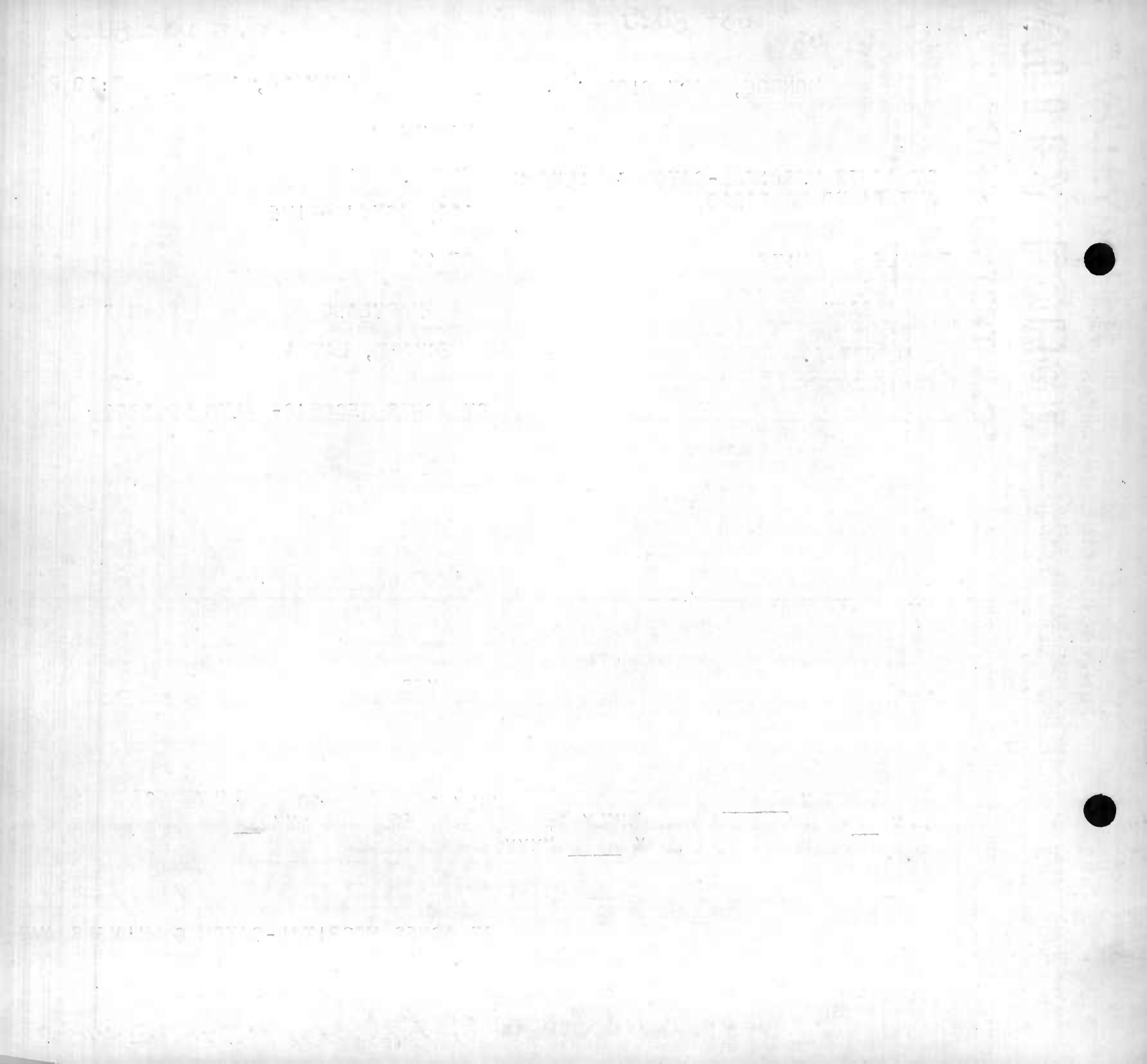
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 8024
BIRTH NO. <u>68-15279</u>		68- 8024 <b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <u>HEATH, BABY GIRL</u>		2. DATE AND HOUR OF DEATH <u>AUGUST 4, 1968</u> <u>4:25 P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>21229</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>ST. AGNES HOSPITAL</u> <u>CATON &amp; WILKENS AVES.</u> <u>BALTIMORE, MD. 21229</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>FEMALE</u> 6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-3-68</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>14</u> <u>4</u> Min.	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>LINWOOD HEATH</u>		14. MOTHER'S MAIDEN NAME <u>JULIANA T. (DEBAUGH) HEATH</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>BALTO., MD. 21229</u> ADDRESS <u>ST. AGNES RECORDS- WILKENS &amp; CATON AVES</u>	
18. <u>774.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <u>Asphyxia Pallida</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>770.0 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Congenital Anemia</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Asphyxia Pallida</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Congenital Anemia</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 3</u> 19 <u>68</u> to <u>AUGUST 4</u> 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>AUGUST 4</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>P. Aziz</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>P. Aziz M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-6-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Garden of Faith</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Witzke Fun. Dir.</u>		25C. FUNERAL DIRECTOR <u>Witzke Fun. Dir., 4101 Edmondson Ave</u>	
VS 150-REV. 1-58		25D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25E. ADDRESS <u>Baltimore, Md. 21229</u>	



# FUNERAL DIRECTOR: IMPORTANT

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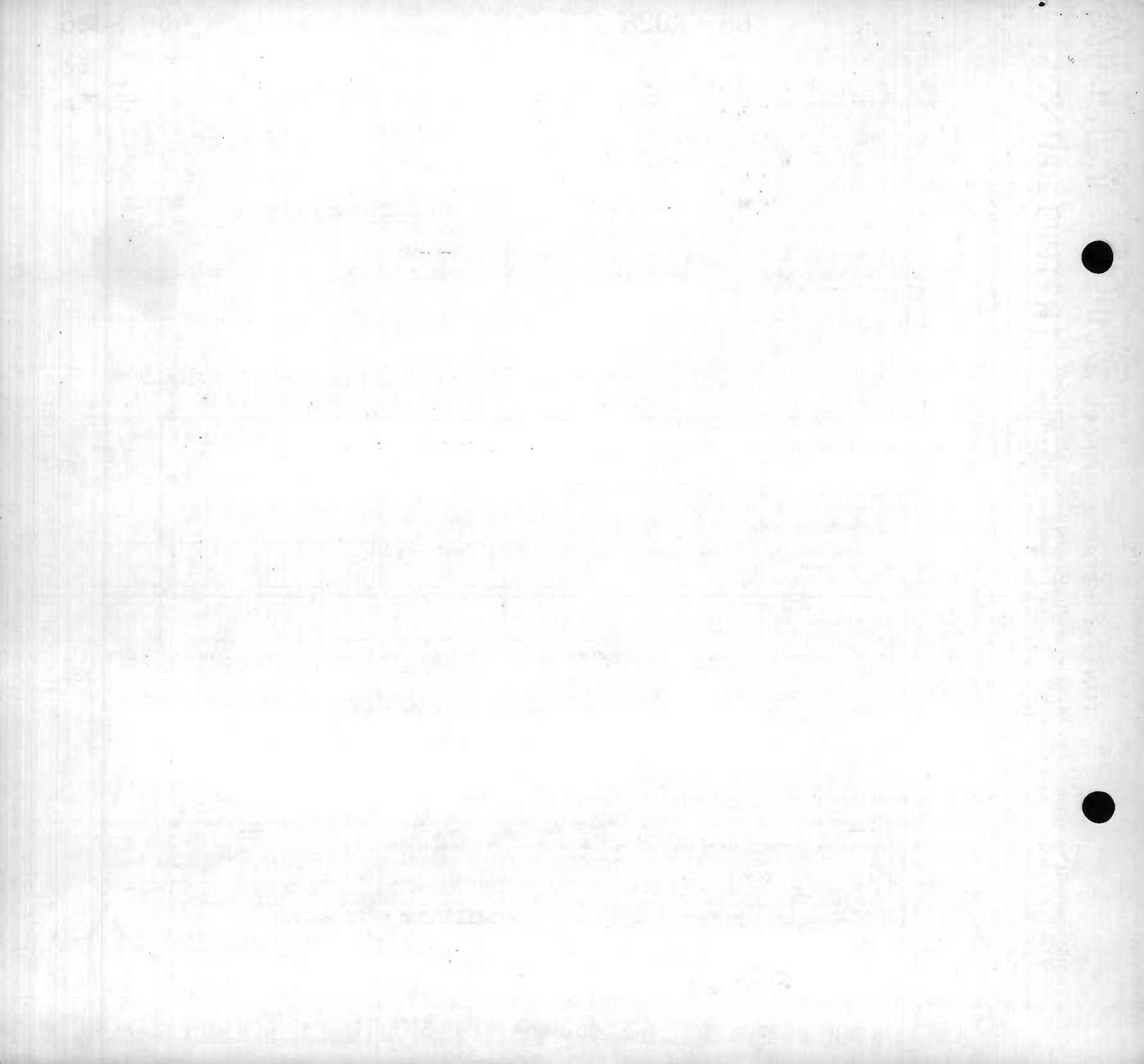
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-8025
BIRTH NO. 68-16316		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>MONROE, BABY GIRL (LORIE ANN)</b>		2. DATE AND HOUR OF DEATH <b>JULY 26, 1968 7:10 P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>9.9.C. 52-00</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST AGNES HOSPITAL-CATON &amp; WILKENS AVE BALTO MD 21229</b>		C. CITY OR TOWN <b>GLEN BURNIE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>1219 ASTER DRIVE</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>07 26 68</b>	9. AGE (In years lost birthday) <b>25</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BABY</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>ALBERT A. MONROE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>ST AGNES RECORDS-BALTO MD 21229</b>
18. <b>776.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>762.5 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Obstetrical</b> (B) <b>Prematurity, 26 weeks</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Gestation</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>2/2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (X) (this hospital) attended the deceased from <b>JULY 26 1968</b> to <b>JULY 26 1968</b> , that (X) (we) lost saw the deceased alive on <b>JULY 26 1968</b> and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Josephina de Castro - Alonso</b>		23B. DATE SIGNED <b>7/29/68</b>		23C. PHYSICIAN'S NAME (Type) <b>MA. JOSEFINA DE CASTRO - ALONSO</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/1/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven</b>
24D. LOCATION (City, town, or county) <b>Glen Burnie Md</b>		24E. FUNERAL DIRECTOR <b>Edmondson</b>		
25A. DATE REC'D AT HEALTH DEPT. <b>AUG 6 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Gentry</b>		25C. ADDRESS <b>4101 Edmondson Dr</b>



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650 68-8026		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-8026	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>IVAN BROWN</b>		2. DATE AND HOUR OF DEATH <b>7/20/68</b> <b>4<sup>20</sup> A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>26-10</b>		C. CITY OR TOWN <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND #21224</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>305 SOUTH EAST AVENUE #21224</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-6-98</b>	9. AGE (In years lost birthday) <b>69</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-10-4927-A</b>		17. INFORMANT <b>BALTIMORE CITY HOSPITALS</b> <b>RECORDS: 4940 EASTERN AVENUE #21224</b>	
18. <b>189.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <b>CARCINOMA of the KIDNEY</b> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs.</b>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-5</b> 19 <b>68</b> to <b>7-20</b> 19 <b>68</b> , that (I) ( <b>6</b> ) last saw the deceased alive on <b>7-20</b> 19 <b>68</b> and that in (my) ( <b>our</b> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Marc E Colmer</b>		23B. DATE SIGNED <b>7-20-68</b>		23C. PHYSICIAN'S NAME (Type) <b>MARC E COLMER M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>8-1-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>UNIVERSITY MEDICAL SCHOOL</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>AUG 6 1968</b>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b>	

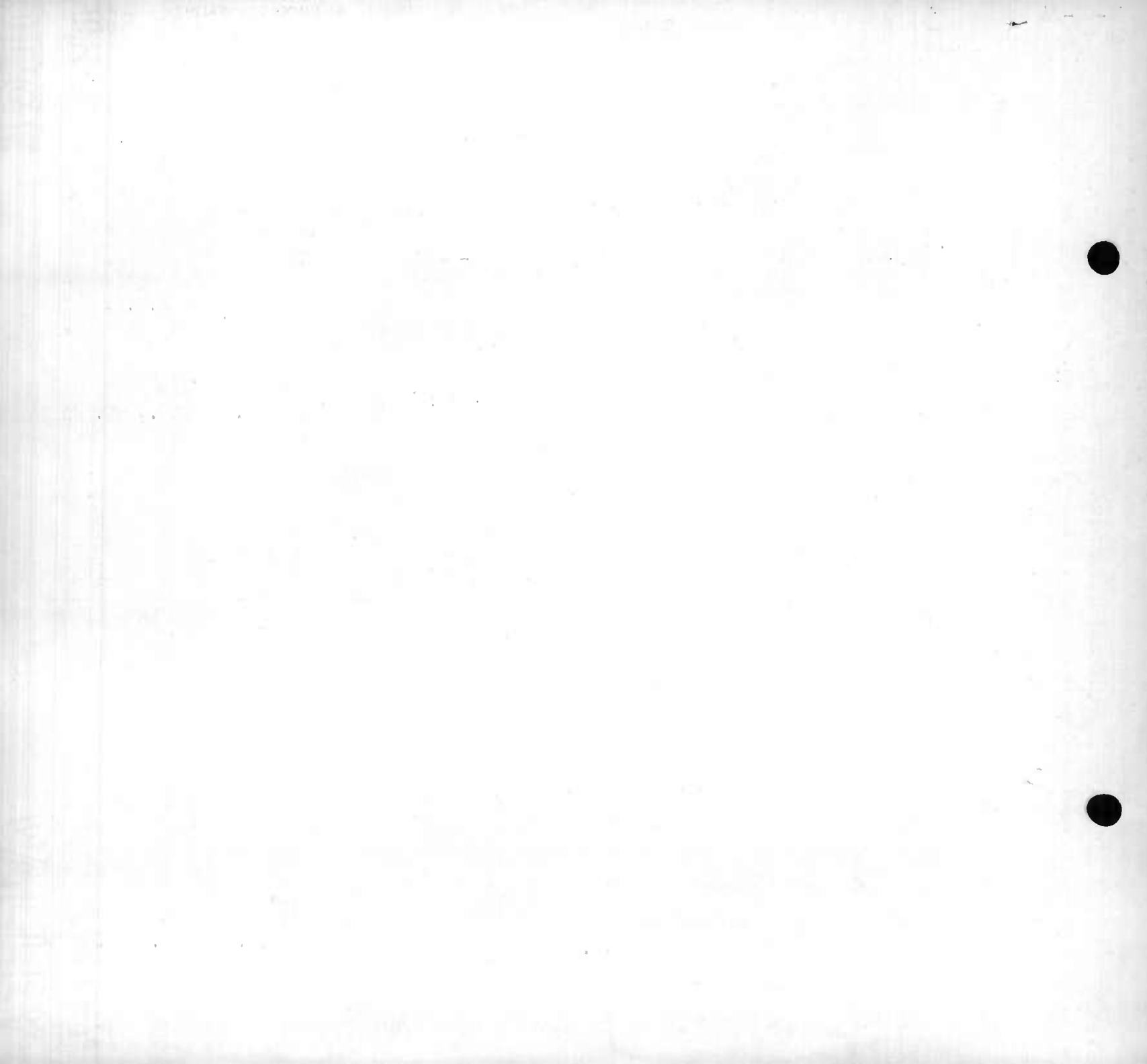


52-02-74  
VLB

FUNERAL DIRECTOR: IMPORTANT

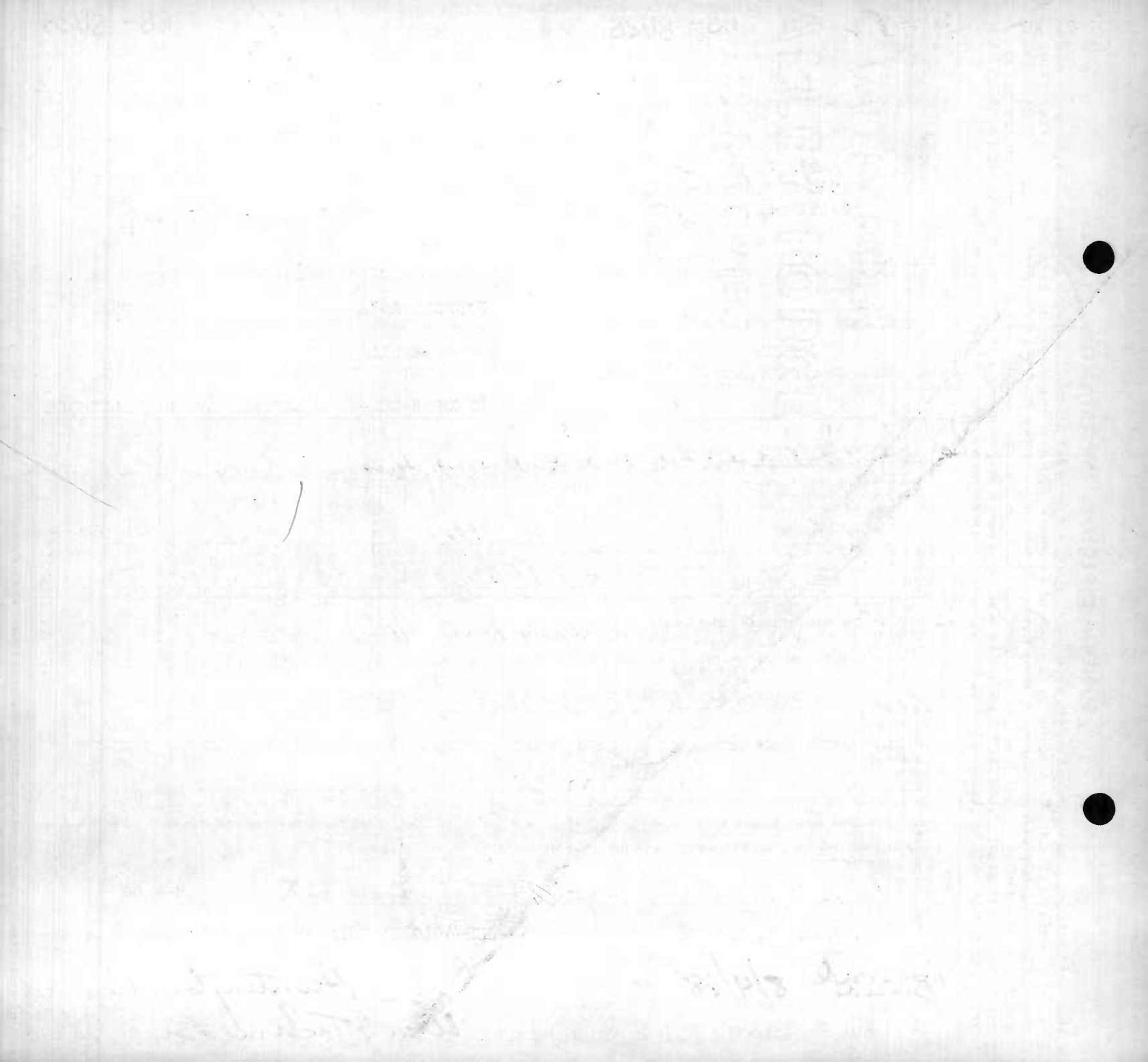
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650		68- 8027		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 8027	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) MARY BROWN			
2. DATE AND HOUR OF DEATH 7/20/68 9 30 P.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2309 ROSLYN AVENUE 21216			
5. SEX FEMALE		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-9-95	
9. AGE (In years lost birthday) 73		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BALTIMORE CITY HOSPITALS 4940 EASTERN AVE., BALTO., MD. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) 285.91-174X PNEUMONITIS DUE TO, OR AS A CONSEQUENCE OF: ASPIRATION 48 hrs. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. (B) SEVERE DEBILITATION DUE TO, OR AS A CONSEQUENCE OF: CHRONIC BRAIN SYNDROME, FLEXION CONTRACTURES, (C) ANEMIA ? CARCINOMA OF B BREAST				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 29 3X II				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 26 19 68 to JULY 20 19 68, that (I) (we) last saw the deceased alive on JULY 20 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph Kaplan M.D.				23B. DATE SIGNED July 20, 1968		23C. PHYSICIAN'S NAME (Type) JOSEPH KAPLAN M.D.	
23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE., BALTO., MD. 21224				23E. LOCATION (City, town, or county) (State)			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE 8-1-68		24C. NAME OF CEMETERY or CREMATORY ANATOLY BOARD OF MARYLAND	
25A. DATE RECEIVED HEALTH DEPT. AUG 6 1968				25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-8028
H-156		68-8028		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Lillie HEFFNER		8/4/68 1:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 31			A. STATE MARYLAND		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224			B. COUNTY BALTIMORE		
			C. CITY OR TOWN		
			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 6119 7314 GEISE AVENUE 21219		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-13-79	9. AGE (In years lost birthday) 89	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				PENNSYLVANIA	
13. FATHER'S NAME JOSEPH		14. MOTHER'S MAIDEN NAME ORDELLA		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MD RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE	
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Embolus (B) ASHED DUE TO, OR AS A CONSEQUENCE OF: Diabetes (C) ...		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate 10 years 15 years	
260X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Urinary tract infection, pneumonia			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-24-68 to 8-4-1968, that (I) (we) lost saw the deceased alive on 8-4-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Paul R. Kalcut				23B. DATE SIGNED 8-4-68	
23C. PHYSICIAN'S NAME (Type) DR. PAUL R. KALCUT				23D. ADDRESS BCH-4940 EASTERN AVENUE, BALTIMORE, MD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8/4/68		24C. NAME OF CEMETERY or CREMATORY Huntington, Penna	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. AUG 6 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR Wm. J. T. ...		25D. ADDRESS		25E. ...	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68- 8029	
CERTIFICATE OF DEATH				REG. NO. <span style="border: 1px solid black; padding: 2px;">X</span>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		NUTH, ROSE C.		AUGUST 5 1968 8:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSPITAL			A. STATE Md. B. COUNTY Baltimore Co		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		
37			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER			624 Rockaway Beach Ave.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	June 17, 1889.	79	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Frank Schindler			Catherine ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Bernard H. Nuth, Jr. Forge Rd. Perry Hall, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
412.4 I			Cerebral infarction		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Cerebrovascular occlusion		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			Atherosclerotic cardiovascular disease		
422.1 II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A)					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (N) (this hospital) attended the deceased from JULY 11 1968 to AUGUST 5 1968, that (I) (we) lost saw the deceased alive on AUGUST 5 1968 and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Joseph Notarangelo M.D.				AUG-5-1968	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
JOSEPH NOTARANGELO M.D.				MERCY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/9/68.		Holy Redeemer Cemetery	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 9 1968		Robert E. Taylor		Leonard J. Ruck, Inc. Balto. Md. 21214	

1-22-63  
10/1/63

MEET 1 10/1/63

MEET 2 10/1/63

MEET 3 10/1/63

MEET 4 10/1/63

MEET 5 10/1/63

MEET 6 10/1/63

MEET 7 10/1/63

MEET 8 10/1/63

MEET 9 10/1/63

MEET 10 10/1/63

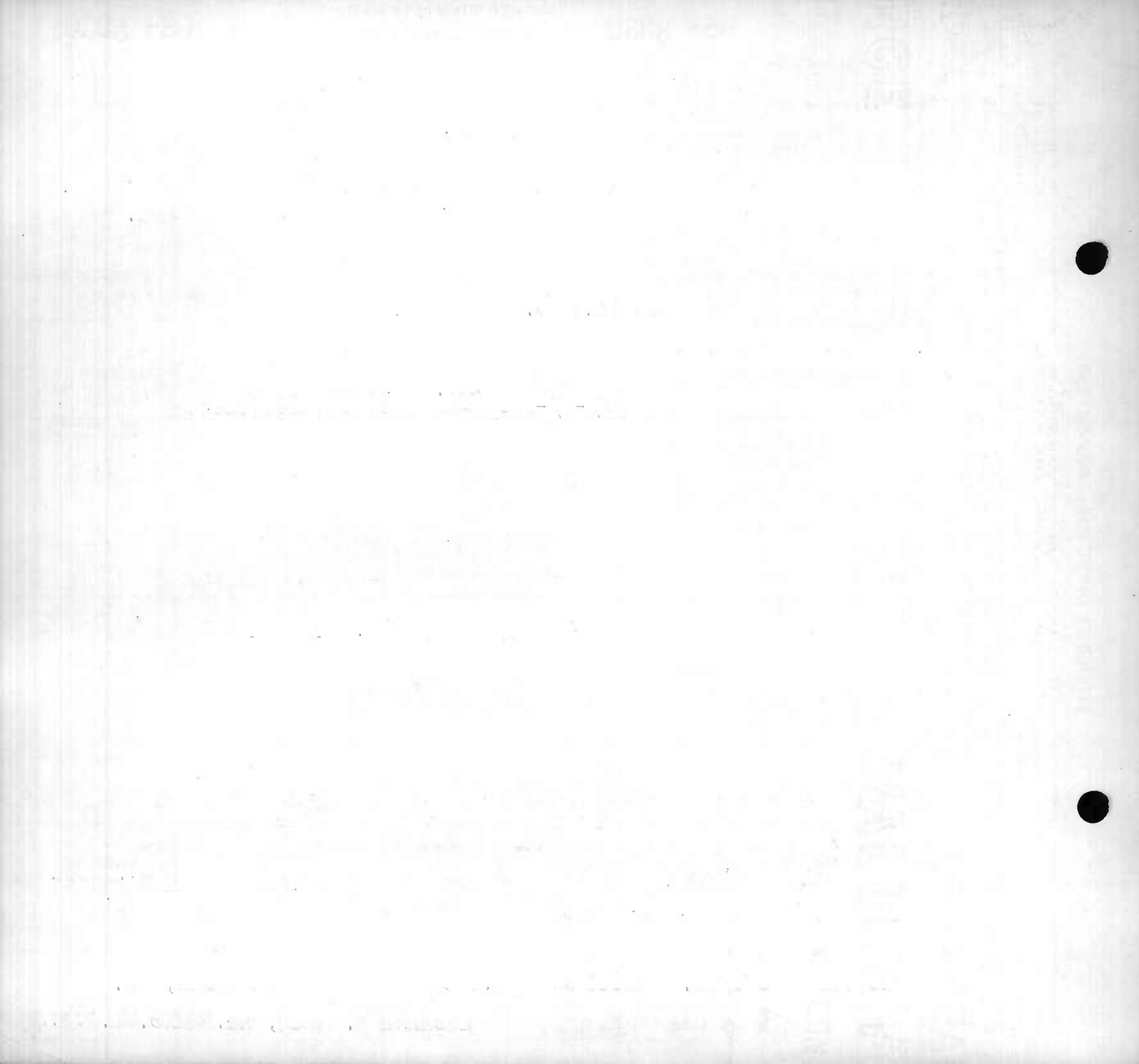
MEET 11 10/1/63

MEET 12 10/1/63

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8030	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>KLEIN, JOHN W.</b>		2. DATE AND HOUR OF DEATH <b>8-5-68 3:50 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-38</b> C. CITY OR TOWN <b>BALTIMORE</b> (If inside city limits? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1907 E. BENEDERE Ave.</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-23-1904</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FOREMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Chemical Co.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>JOHN W. KLEIN, SR.</b>		
14. MOTHER'S MAIDEN NAME <b>AMANDA CRAMBLITT</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>717-07-8683</b>			17. INFORMANT <b>Mrs. Lillian Pitta</b> <del>John W. Klein, Jr.</del> ADDRESS <b>See above</b>		
18. <b>492X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,  <b>527.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>BLEEDING PEPTIC ULCER</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>BRONCHO PNEUMONIA, PROBABLE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>
			(B) <b>CHRONIC EMPHYSEMA</b> DUE TO, OR AS A CONSEQUENCE OF:		
			(C) <b>BLEEDING PEPTIC ULCER</b>		<b>16 DAYS</b>
19A. DATE OF OPERATION <b>8-5-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>7-20</b> 19 <b>68</b> to <b>8-5</b> 19 <b>68</b> , that <del>we</del> (we) last saw the deceased alive on <b>8-5</b> 19 <b>68</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Miguel Sanchez-Palacios</b>				23B. DATE SIGNED <b>Aug 5, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>MIGUEL SANCHEZ-PALACIOS</b>				23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/8/68.</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Cemetery</b>	
24D. LOCATION <b>Baltimore, Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>AUG 6 1968</b>			
25A. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25B. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8031

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68- 8031

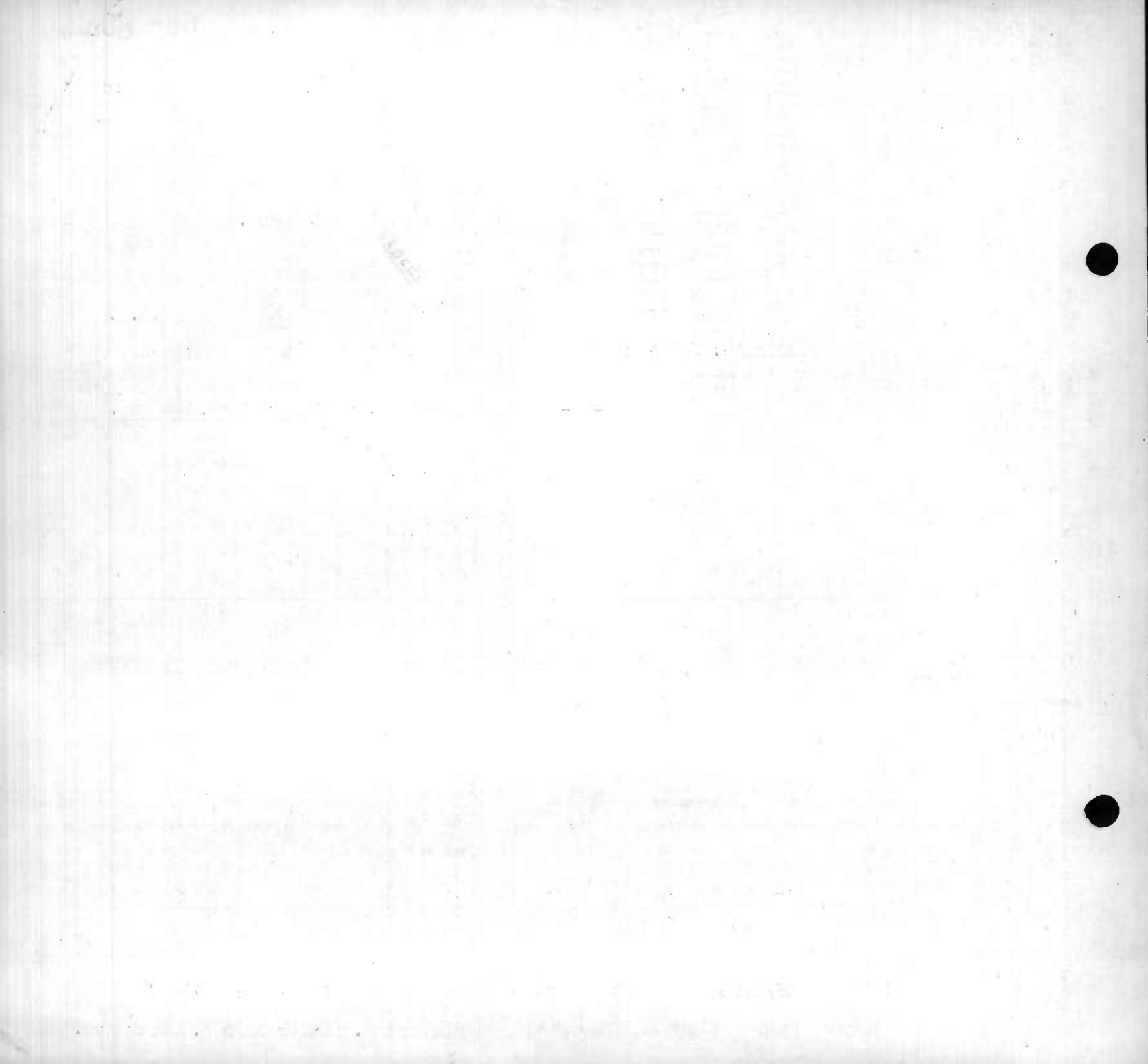
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Lottie May Lee Downs</b>		2. DATE AND HOUR OF DEATH <b>August 2, 1968</b> <b>7: A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-09</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3919 Bateman Ave.</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>Female</b> 6. RACE <b>Colored</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>July 8, 1878</b>		9. AGE (In years last birthday) <b>90</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Governess</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Pvt. Family</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>George Buchanan</b>		
14. MOTHER'S MAIDEN NAME <b>Nellie Downs</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Nellie A. Buchanan-3919 Bateman Ave.</b>		
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Carcinomatosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Adeno-Carcinoma of Breast.</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>24 months</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>9 months</b> (C) _____		
19. DATE OF OPERATION			20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED		
21F. HOW DID INJURY OCCUR?			21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
22. I certify that (I) (this hospital) attended the deceased from <b>1966 August</b> 19 to <b>Aug. 1</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Aug. 1, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			23B. DATE SIGNED <b>8-5-1968</b>		
23A. SIGNATURE <b>I. Bradshaw Higgins</b>			23C. PHYSICIAN'S NAME (Type) <b>Dr. I. Bradshaw Higgins MD</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>8/6/68</b>		
24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore, County Maryland</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 6 1968</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		
25C. FUNERAL DIRECTOR <b>Herbert E. Nutter-3035 W. North Ave.</b>			25D. ADDRESS		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-8032</b>
BIRTH NO.				
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
Katie L. Smith		8/1/68 8:06 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  00 3707 Harlem Ave.		A. STATE Maryland B. COUNTY 16-08 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3707 Harlem Ave.		
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/30/85	9. AGE (In years last birthday) 82
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10B. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William C. Johnson		14. MOTHER'S MAIDEN NAME Harriet Stansbury Anderson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-05-3462D	17. INFORMANT Mrs Mamie E. Smith 3707 Harlem Ave.	
18. <b>404X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Respiratory failure DUE TO, OR AS A CONSEQUENCE OF: (B) Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: Cholesterol (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>442X II</b>				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>July 31 1968</u> to <u>Aug 1 1968</u> , that (I) (we) last saw the deceased alive on <u>July 31 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>S. Botzofsky</i>		23B. DATE SIGNED 8/3/68		23C. PHYSICIAN'S NAME (Type) S BOTZOFSKY
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/5/68		24C. NAME of CEMETERY or CREMATORY Mount Auburn Cemetery
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 6 1968		
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Herbert E. Nutter 3035 W. North Ave.		



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8033

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ROSA GILLESPIE</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>August 3, 1968</b>		Hour <b>6:30 P.M.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1203 W. Lanvale Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>August 3, 1968</b>		Hour <b>6:30 P.M.</b>
6. SEX <b>female</b>		7. RACE <b>negro</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH <b>July 2, 1877</b>		10. AGE (In years lost birthday) <b>91</b>		11. BIRTHPLACE (State or foreign country) <b>N.C.</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Walter Gillespie</b>		14. MOTHER'S MAIDEN NAME <b>Victoria MacIntyre</b>
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>212-18-477</b>
18. INFORMANT <b>Willie Barnett</b>		19. ADDRESS <b>1203 W. Lanvale St</b>		20. CAUSE OF DEATH <b>Arteriosclerotic Cardiovascular Disease</b>
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arteriosclerotic Cardiovascular Disease</b>		23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>4221</b>
24A. DATE OF OPERATION <b>8/1/68</b>		24B. CONDITION FOR WHICH OPERATION WAS PERFORMED		24C. AUTOPSY? (Yes or No) <b>No</b>
25A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		25B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		25C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
25D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		25E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		25F. HOW DID INJURY OCCUR?
26. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8/4/68</b>
27A. BURIAL CREMATION, REMOVAL (Specify) <b>Shipped</b>		27B. DATE <b>8/1/68</b>		27C. NAME OF CEMETERY or CREMATORY <b>Silver Hill Cem</b>
27D. LOCATION (City, town, or county) (State) <b>Hamlet N.C.</b>		27E. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		27F. FUNERAL DIRECTOR <b>Williams Funeral Home</b>
27G. ADDRESS <b>319 N. Schroeder</b>				

88-3033

Doc 803

1/2/87

N.C.

Historic

Water Filtration  
Water Treatment  
Sewerage & Sanitation

VALLEY REGION

VALLEY REGION

WATER & SEWER

Sheet 8 of 8

Water & Sewerage

68- 8034

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8034

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)A.  
WILLIAM BARNES2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

8

4

68

11:30 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

City Hospitals D.O.A.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

August

4

1968

11:30 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Balto.

YES ☒NO ☐

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. DATE OF BIRTH

1/25/182

10. AGE (In years  
last birthday)

86

If Under 1 Yr. If Under 24 Hrs.  
Months, Days, Hours, Min.

E. STREET AND NUMBER

33 S. Curley St.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Uriah H. Barnes

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Machinist Helper

14B. KIND OF BUSINESS OR INDUSTRY

Continental Co.

15. MOTHER'S MAIDEN NAME

Martha W. Firzzell

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

218-03-2687

18. INFORMANT

ADDRESS

Miss Helen G. Barnes 33 S. Curley St

19.

41241

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES (Head)

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Ronald N. Fornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 5, 1968

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8/8/68

24C. NAME OF CEMETERY or CREMATORY

Parkwood Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 6 1968

25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Baltimore St.

1015

WALLLEY F. D. B. C.

159,444 8/1/1917

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8035

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

VANESSA LUCAS

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

July 31, 1968

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Church Home Hospital (DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

P. M.

July 31, 1968

3:04 P. M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☒NO ☐

6. SEX

Female

7. RACE

Negro

B. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

5/7/64

10. AGE (In years  
last birthday)

4

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

200 N. Aisquith Street

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF

U S A

13. FATHER'S NAME

Willie Lee Graham

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Child

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Lucille Lucas

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Mrs Lucille Lucas, same

19. E988X

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Cerebro-cranial injuries  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

E936.0 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

home

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

200 N. Aisquith Street

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

?

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 1, 1968

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8/5/68

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cemetery

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 6 1968

25B. NAME OF REGISTRAR

R. E. Finkbeiner

25C. FUNERAL DIRECTOR

A

Halstead

1206 W

North Ave

1592-30

1. The first part of the report is a general description of the project.

2. The second part is a detailed description of the methodology used.

3. The third part is a description of the results of the study.

4. The fourth part is a discussion of the findings.

5. The fifth part is a conclusion and recommendations.

6. The sixth part is a list of references.

7. The seventh part is an appendix containing additional data.

8. The eighth part is a glossary of terms.

9. The ninth part is a list of figures and tables.

10. The tenth part is a list of abbreviations.

11. The eleventh part is a list of symbols.

12. The twelfth part is a list of units.

13. The thirteenth part is a list of acronyms.

14. The fourteenth part is a list of definitions.

15. The fifteenth part is a list of footnotes.

16. The sixteenth part is a list of endnotes.

17. The seventeenth part is a list of appendices.

18. The eighteenth part is a list of references.

19. The nineteenth part is a list of symbols.

20. The twentieth part is a list of units.

21. The twenty-first part is a list of acronyms.

22. The twenty-second part is a list of definitions.

1/21/20

WALL 144 F O R C I E

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Neddie McFadden</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> 8 2 68 Hour 11:50 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>36 Franklin Square Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 2 68 12:00 Midnight	
6. SEX <b>M</b>		7. RACE <b>C</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>1926</b>		10. AGE (In years last birthday) <b>42</b>	
11. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>MR WEARY MCFADDEN</b>		ADDRESS <b>1002 Girard St. Washington D.C.</b>	
19. <b>E966X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Stabwound of chest</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>200 Block N. Carleton St.</b>		22F. HOW DID INJURY OCCUR? <b>stabbed during altercation</b>	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour <b>8 2 68 11:30 P.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> EXAMINER'S NAME (Type) DATE SIGNED <b>Aug. 3, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/8/68</b>	
24C. NAME of CEMETERY or CREMATORY <b>Mt Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 6 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>1206 W North Ave</b>	

10-10-60

10-10-60

WALLS & K. POH

WALLS & K. POH

10-10-60

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8037 CERTIFICATE OF DEATH

REG. NO. 68- 8037

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Jack C. Wilson</b>		2. DATE AND HOUR OF DEATH <b>8/4/68 6:30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>815 Burgundy St.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>C</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. AGE (In years last birthday) <b>60</b>		9. AGE (In years last birthday) <b>60</b>		10. AGE (In years last birthday) <b>60</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Mose Wilson</b>		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>248-01-2117</b>		17. INFORMANT <b>Lila Mae Wilson 815 Burgundy St.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hypertensive &amp; Arteriosclerotic</b>		(C) <b>Coronary vascular disease</b>			
19A. DATE OF OPERATION <b>442X II</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>December 1967</b> to <b>April 4 1968</b> , that (I) (we) last saw the deceased alive on <b>July 15 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. Shorofsky</b>		23B. DATE SIGNED <b>8/5/68</b>		23C. PHYSICIAN'S NAME (Type) <b>S B Kofsky</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/8/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>	
25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>		25D. ADDRESS <b>661 W. Barre St.</b>			

Respectfully

My father & mother

June 12

J. H. H. H.

1871

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 8038

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>CHARLES T. Verna JR</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> August 3, 1968 Hour: 9:00 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>835 S. Dallas Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour August 4, 1968 10:00 A.M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY <b>3-02</b> C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 1927 Oct 12 1926		10. AGE (In years last birthday) -42 40 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Danville		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ALCOA ALUMN.		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WORLD WAR II		17. SOCIAL SECURITY NO. 225-30-8917	
15. MOTHER'S MAIDEN NAME Elizabeth A. Thibodeau		18. INFORMANT ADDRESS MARGARET BELL 835 S DALLAS ST.	
19. 303.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ACUTE ALCOHOLIC (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: INTOXICATION (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 3-22-0 II		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) Yes	
ACTUAL EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 8/4/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug 8, 1968	
24C. NAME OF CEMETERY or CREMATORY Sherwood Mem. PK.		24D. LOCATION (City, town, or county) (State) Salem, Va.	
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Lotz Funeral Home		ADDRESS Salem Va.	

Letter from Funeral Director

8-12-68 M.H.

YES WOULD MR H

VALLEY FLOW

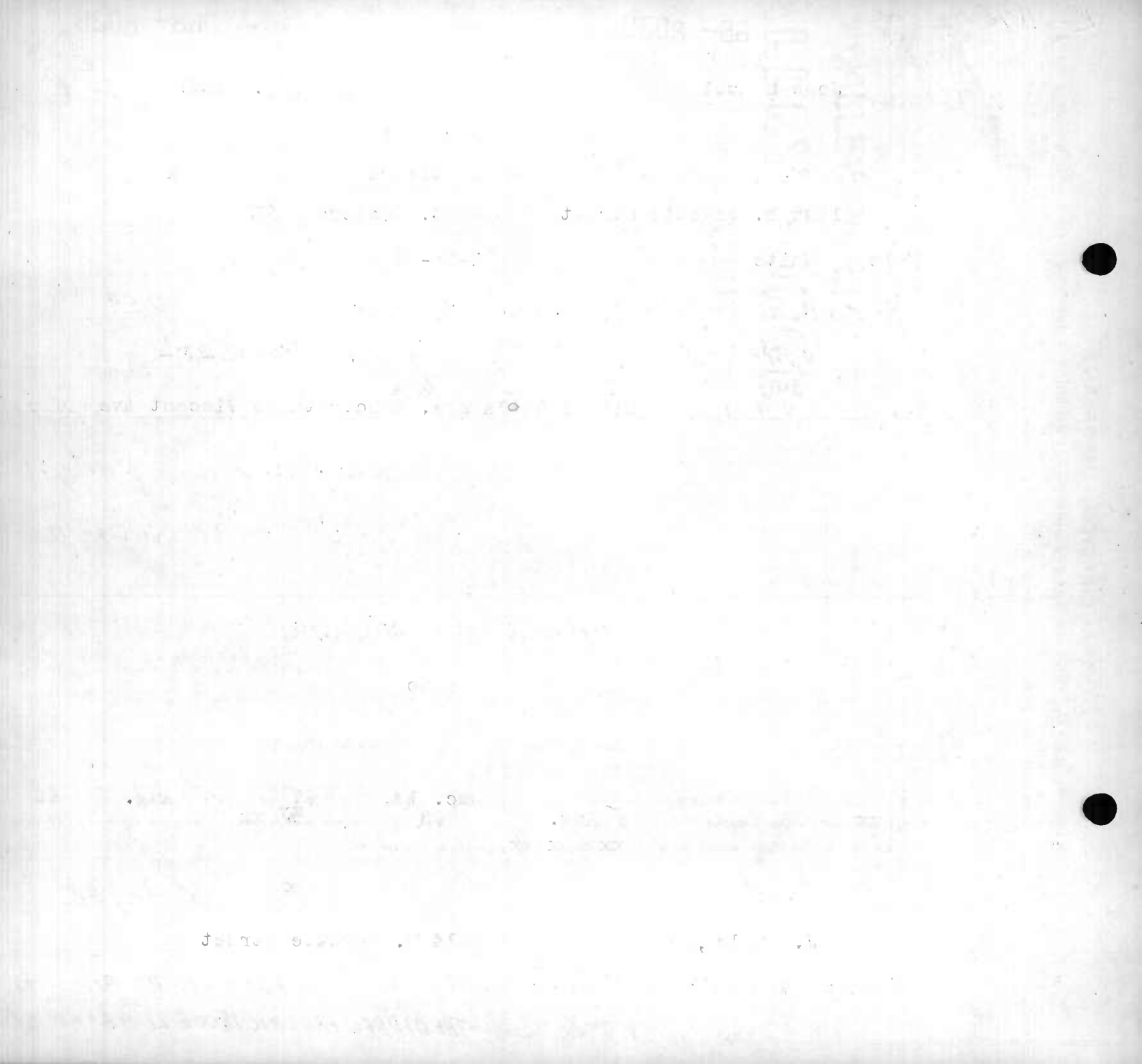
*Wm. J. ...*

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 8039

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Joseph Robl</b>		2. DATE AND HOUR OF DEATH <b>5 Aug. 1968 945 P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 FAYETTE CONVALESCENT HOME</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
ADDRESS OR LOCATION <b>1105 E. Fayette Street</b>			E. STREET AND NUMBER <b>28 S. Madiera ST.</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-18-1908</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Service-Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JOSEPH Robl</b>			
14. MOTHER'S MAIDEN NAME <b>Pauline Schramm</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>			
16. SOCIAL SECURITY NO. <b>213 01 3863A</b>		17. INFORMANT <b>RITA</b> ADDRESS <b>Mrs. Stuckrath 25 Vincent Ave 21221</b>			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>492X I</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>527.1 II</b>					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Emphysema</b>					
(B) DUE TO, OR AS A CONSEQUENCE OF: <b>ASCD</b>					
(C) DUE TO, OR AS A CONSEQUENCE OF: <b>cataracts/malnutrition</b>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>past yr</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(did)</del> attended the deceased from <b>Dec. 19, 1967</b> to <b>5 Aug. 1968</b> , that (I) <del>(did)</del> lost saw the deceased alive on <b>5 Aug. 1968</b> and that in my <del>(my)</del> <b>my</b> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(did)</del> <b>did</b> view the body after death.					
23A. SIGNATURE <b>J. Hulla MD</b>				23B. DATE SIGNED <b>5 Aug 68</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. Hulla, MD</b>				23D. ADDRESS <b>2214 E. Fayette Street</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>AUG 9-68</b>		24C. NAME of CEMETERY or CREMATORY <b>BALTIMORE NATIONAL</b>	
24D. LOCATION <b>FREDERICK RD BALTO MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 6 1968</b>			
25B. NAME OF REGISTRAR <b>R. E. F. F. F.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>THE DIPPEL BROS INC 1800 E LOMBARD ST</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68- 8040	
<div style="display: flex; justify-content: space-between;"> <span>68- 8040</span> <span style="font-size: 1.5em;">CERTIFICATE OF DEATH</span> </div>					
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH August 1, 1968			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2727 Harlem Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4-15-1898	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greenville, N.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME LEVI ROLLINS			14. MOTHER'S MAIDEN NAME LYDIA MOORE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 238-28-7694	17. INFORMANT Mrs. Eva Rollins 2727 Harlem Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO CVA (B) DUE TO Rt. Hemiplegia due to CVA (C) DUE TO Amputation of Rt. Leg.	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 331X II Chronic Brain Syndrome				INTERVAL BETWEEN ONSET AND DEATH 2 days 1 yr. 1 yr.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 10, 1968 to August 1, 1968, that (I) (we) last saw the deceased alive on August 2, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E.E. Holt				23B. DATE SIGNED 8/5/68	
23C. PHYSICIAN'S NAME (Type) E.E. Holt				23D. ADDRESS 3715 Liberty Hgts. Ave. Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-5-68		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 6 1968			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR MORTON & DYETT F.H. 1701 Laurens St.			

24/10

AVD

1/1

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AVD

24/10

24/10

24/10

24/10

24/10

24/10

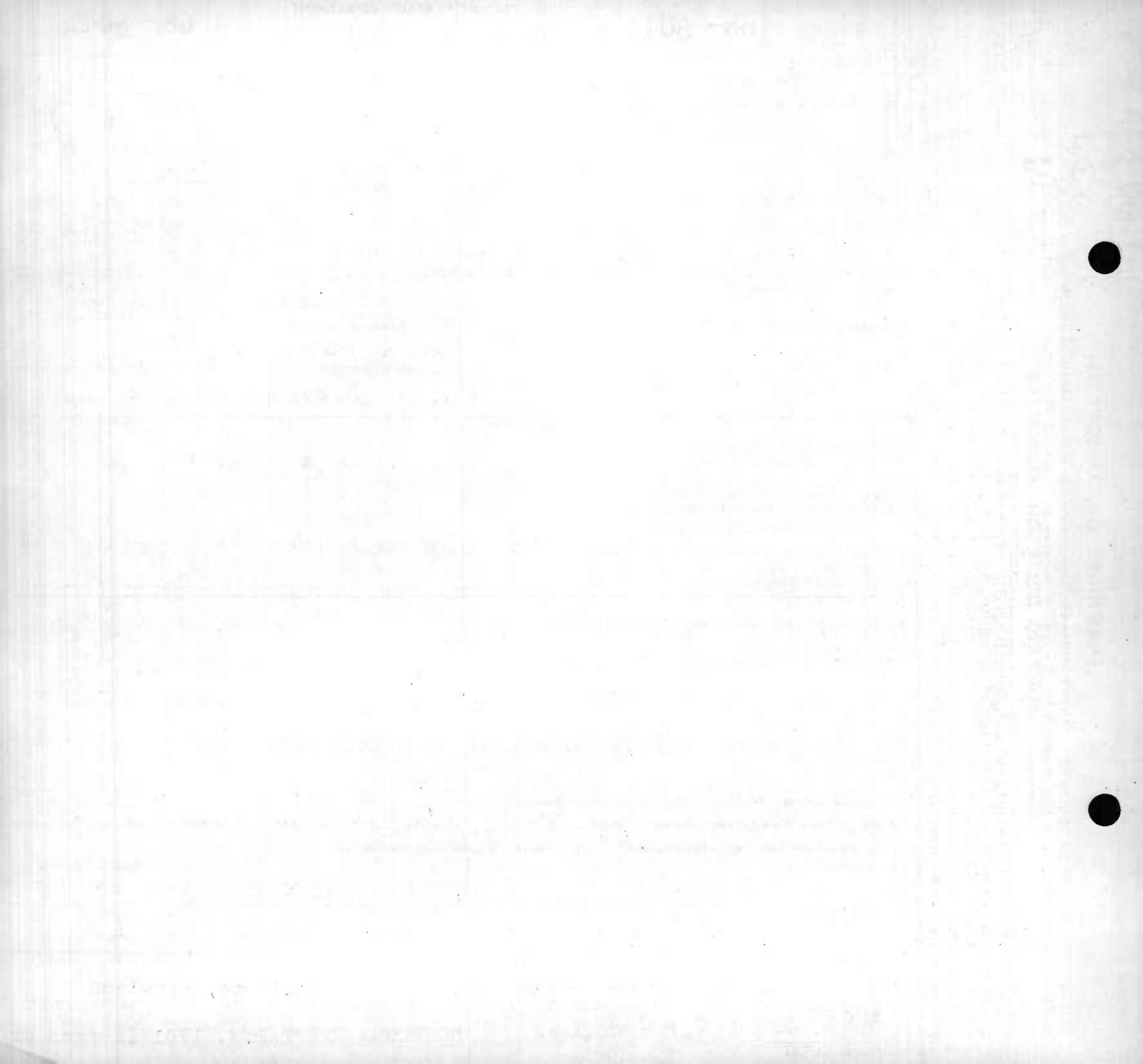
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 68- 8041 CERTIFICATE OF DEATH

REG. NO. 68- 8041

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Thomas Whiting</b>		2. DATE AND HOUR OF DEATH <b>August 4, 1968 10:35 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>17-01</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>U.S. Public Health Service Hospital</b> <b>Wyman Pl. DRWB &amp; 31st Street</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>Wilmer Ct, No-916</b>		
5. SEX <b>M</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Febr. 12, 1900</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>stevedore-longshoreman</b>			11. BIRTHPLACE (State or foreign country) <b>Balto, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Thomas T. Whiting</b>			14. MOTHER'S MAIDEN NAME <b>Geneva Hargrove</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>212-01-8970</b>		17. INFORMANT <b>Records-US PHS Hospital, Balto, Md.</b>
18. <b>436.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebro vascular accident</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>331X II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>July 30, 1968</b> to <b>August 4, 1968</b> , that <del>the</del> (we) last saw the deceased alive on <b>August 4, 1968</b> and that in <del>the</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>We</del> (We) (did) <del>did not</del> view the body after death.					
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>8-4-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>MIHALY BARTALOS, SR. Surg. (R)</b>				23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-8-68</b>		24C. NAME of CEMETERY or CREMATORY <b>Mount Auburn Cem.</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 6 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>	
				ADDRESS <b>1701 Laurens St</b>	



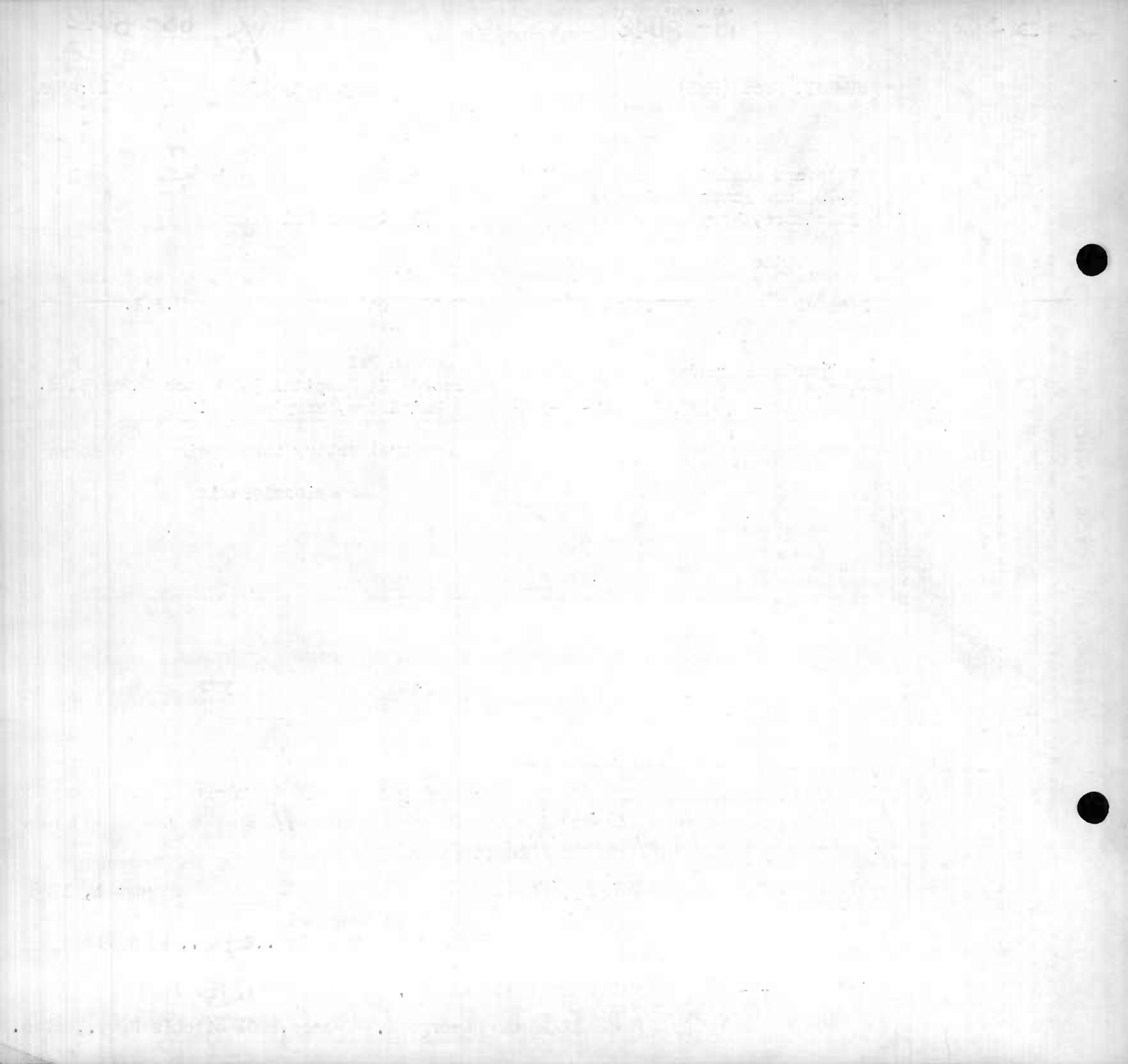
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8042

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 8042

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>SUNDAY, Fred (NMI)</b>		2. DATE AND HOUR OF DEATH <b>August 1, 1968</b>   <b>10:45 A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>9.9.6 52-00</b>		C. CITY OR TOWN <b>Odenton</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>		E. STREET AND NUMBER <b>533 Higgins Drive</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/24/96</b>	9. AGE (In years lost birthday) <b>71</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Indianana</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <b>Bertha Heir</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 8/5/17 - 1/23/19</b>		16. SOCIAL SECURITY NO. <b>713-05-3574</b>		17. INFORMANT ADDRESS <b>Records VA Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218</b>	
18. <b>433.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Cerebral artery thrombosis</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerosis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>	
332X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>yes</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>1/1</b> (this hospital) attended the deceased from <b>February 3rd 1968</b> to <b>August 1st 1968</b> , that <b>1/1</b> (we) last saw the deceased alive on <b>August 1st 1968</b> and that in <b>1/1</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>1/1</b> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Susan H. Mather</i>				23B. DATE SIGNED <b>August 1, 1968</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>VA Hospital 3900 Loch Raven Blvd., Balto., Md 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-5-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cem.</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. DATE REC'D BY HEALTH DEPT. <b>AUG 6 1968</b>		24F. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
24G. FUNERAL DIRECTOR <b>George J. Gonce</b>		24H. ADDRESS <b>4001 Ritchie Hgwy., Balto.</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68-8043 CERTIFICATE OF DEATH

REG. NO. 68-8043

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

GREEN, Cecil

2. DATE AND HOUR OF DEATH

July 29/1968 3:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)33  
Johns Hopkins Hospital4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

1910 E. Pratt St.

5. SEX

Male

6. RACE

White

7. MARRIED

NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

4-19-07

9. AGE (In years  
last birthday)

61

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Miner

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Wharton, West Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Summers, Green

14. MOTHER'S MAIDEN NAME

Emma Green 1910 E. Pratt Street

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Junior McCauley 1910 E. Pratt St.

18. 412.41

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Pulmonary embolism

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

2 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B) ASCVD

DUE TO, OR AS A CONSEQUENCE OF:

years

(C)

422.1 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

No

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from July 2 19 68 to July 29 19 68  
that (1) (we) last saw the deceased alive on July 29 19 68 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Joseph S. Atkinson

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

7/29/68

23C. PHYSICIAN'S  
NAME (Type)

Joseph S. Atkinson

DEGREE

23D. ADDRESS

The Johns Hopkins Hospital

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8-2-68

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Bim West Virginia

25A. DATE REC'D BY HEALTH DEPT.

AUG 6 1968

25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

ADDRESS

Hunter &amp; Hunter Madison West Virginia

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Handwritten text, possibly a date or signature, located in the middle left quadrant of the page.

Handwritten text, possibly a date or signature, located in the lower left quadrant of the page.

Handwritten text, possibly a date or signature, located in the upper right quadrant of the page.

Handwritten text, possibly a date or signature, located in the middle right quadrant of the page.

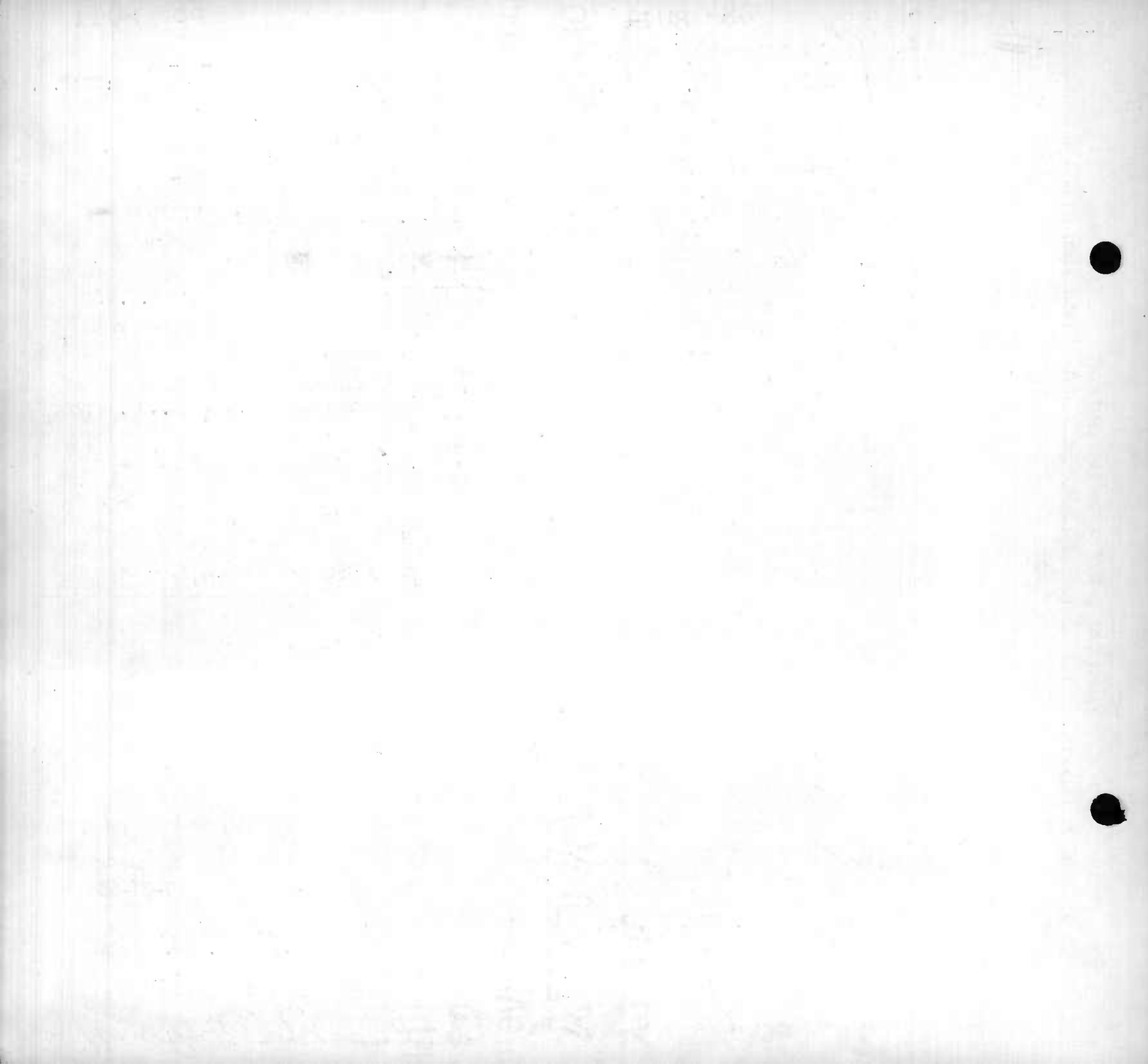
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52-21-91

FUNERAL DIRECTOR: IMPORTANT

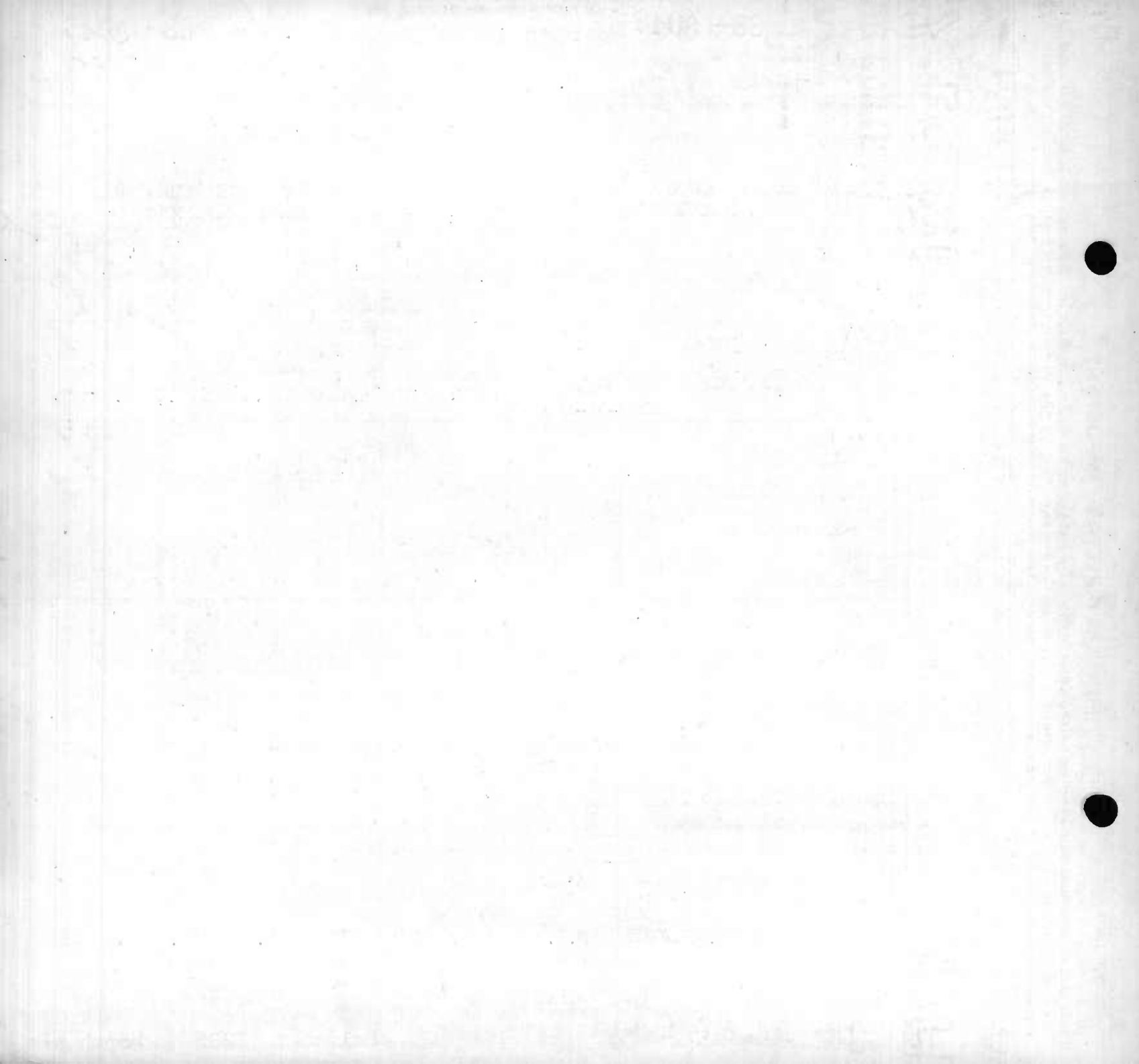
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-650		68-8044		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-8044	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>GREEN, HENRY R.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH <b>7-31-68</b> <b>7/31 6:00 P.M.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVE.</b> <b>BALTIMORE, MARYLAND 21224</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> C. CITY OR TOWN <b>BALTIMORE</b> E. STREET AND NUMBER <b>809 S. HANOVER STREET 21230</b>			
5. SEX <b>MALE</b>		6. RACE <b>NEGRO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <b>59</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY</b>				14. MOTHER'S MAIDEN NAME <b>BROWN, LIZZIE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVE., BALTO., MD. 21224</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTecedent CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>420.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Myocardial Infarction, Congestive</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Failure + probable underlying cause</b>			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7/27/1968</b> to <b>7/31/1968</b> , that (I) (we) last saw the deceased alive on <b>7/31/68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Owen S. Surman, M.D.</b>				23B. DATE SIGNED <b>7-31-68</b>		23C. PHYSICIAN'S NAME (Type) <b>Owen S. Surman, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>8/5/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mount Calvary</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 7 1968</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>108 W. Montgomery St.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
E-363 68-8045		CERTIFICATE OF DEATH		68-8045	
1. NAME OF DECEASED (Type or Print) <i>Annie Edwards</i>		2. DATE AND HOUR OF DEATH <i>8/3/68</i> <i>5:55 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i> <i>BALTIMORE CITY HOSPITALS</i> <i>4940 EASTERN AVENUE</i> <i>BALTIMORE, MARYLAND 21224</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>ANNE ARUNDEL</i> C. CITY OR TOWN <i>52-00</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>7355 FURNACE BRANCH ROAD</i> <i>PLAZA-MANOR NURSING HOME 21061</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>86</i>	9. AGE (In years last birthday) <i>86</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>OLD AGE</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MD</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		13. FATHER'S NAME <i>CLAIBORNE WAYKINS</i>		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>217-54-4612-JI</i>		17. INFORMANT ADDRESS <i>BCH: 4940 EASTERN AVE., BALTO., MD. 21224</i>	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Artery Disease</i> (B) MYOCARDIAL INFARCTION (C) ARTERIOCLEROTIC CARDIOVASCULAR DISEASE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>420.1 II</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8/2/68</i> to <i>8/3/68</i> , that (I) (we) last saw the deceased alive on <i>8/3/68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Kenneth E. Fligsten</i> M.D. DEGREE		23B. DATE SIGNED <i>8/3/68</i>		23C. PHYSICIAN'S NAME (Type) <i>KENNETH E. FLIGSTEN M.D.</i> DEGREE	
23D. ADDRESS <i>BCH: 4940 EASTERN AVE., BALTO., MD. 21224</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>8/9/68</i>	24C. NAME of CEMETERY or CREMATORY <i>Mt. Calvary Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>A A County Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 7 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>A Halstead 1206 W North Ave</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8046

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 8046

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>SPARROW MARVIN</b>		2. DATE AND HOUR OF DEATH <b>8-6-68 2:30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>10-01</b>		C. CITY OR TOWN <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>	6. RACE <b>Negroid</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-6-91</b>	9. AGE (In years last birthday) <b>76</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hardyman (R) RAPPERS CO</b>
11. BIRTHPLACE (State or foreign country) <b>N.C.</b>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>MARVIN SPARROW</b>	
14. MOTHER'S MAIDEN NAME <b>JULIA MASON</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-05-4501</b>	
17. INFORMANT <b>Sheryl BRADLEY 1049 Harford Ave</b>		ADDRESS		18. <b>150 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
19. <b>150 X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma of the Esophagus</b> 1 year		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>1 year</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>7/1/68</b> 19 to <b>8/6</b> 19 <b>68</b> , that (1) (we) lost saw the deceased alive on <b>8/6</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jeffrey D. Neill</b>		23B. DATE SIGNED <b>8/6/68</b>		23C. PHYSICIAN'S NAME (Type) <b>Jeffrey D. Neill</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-9-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT. CALVARY</b>	
24D. LOCATION <b>A. A. COUNTY, M.D.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbanks</b>	
25C. FUNERAL DIRECTOR <b>Joseph H. Rock Jr</b>		25D. ADDRESS <b>1304 N. Central Ave</b>		25E. ADDRESS	

18-11-18  
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# FUNERAL DIRECTOR: IMPORTANT

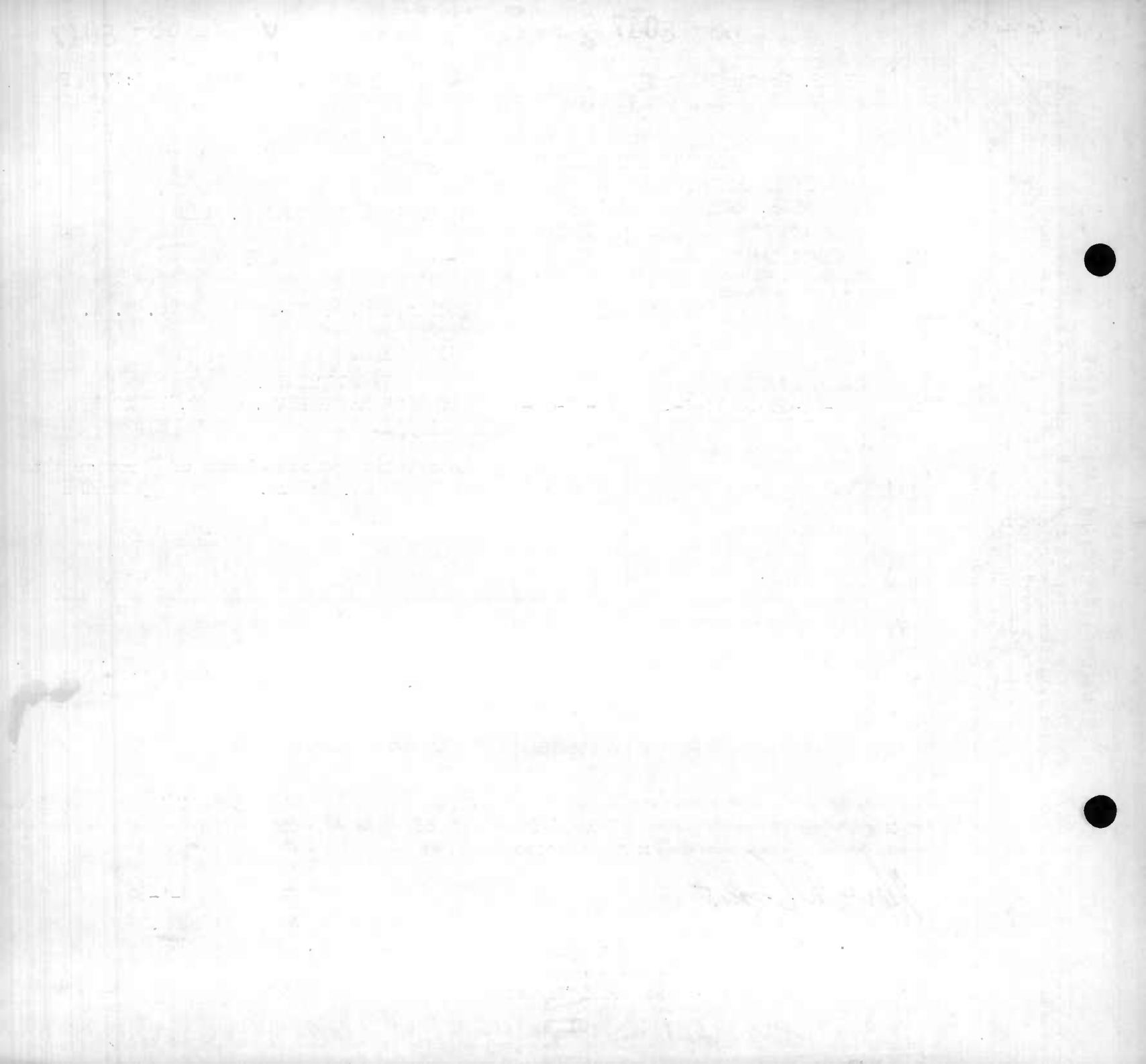
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-626

68-8047 BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68-8047

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MYERS, Martin Edward		2. DATE AND HOUR OF DEATH 3 AUGUST 1968 5:17 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY CARROLL C 56-00		C. CITY OR TOWN HAMPSTEAD D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218		E. STREET AND NUMBER 16 UPPER BECKLEYSVILLE ROAD			
5. SEX MALE	6. RACE CAUCASION	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-1-08	9. AGE (In years lost birthday) 59	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICK MASON		10B. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) WESTMINSTER, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME EDWARD MYERS		14. MOTHER'S MAIDEN NAME ELLIE MYERS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 3-26-43 TO 11-8-45		16. SOCIAL SECURITY NO. 215-07-48-01		17. INFORMANT VA HOSPITAL RECORDS 3900 LOCH RAVEN BLVD, BALTO, MD 21218	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastatic Apenocarcinoma of the Rectum. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Greater than 3 Months	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 154 X II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (X) (this hospital) attended the deceased from 20 JUNE 19 68 to 3 AUGUST 19 68, that (X) (we) last saw the deceased alive on 3 AUGUST 19 68 and that in (X) (our) opinion death occurred on the date and hour and from the cause stated above. (X) (We) (did) (not) view the body after death.			
23A. SIGNATURE Hewes D. Agnew		23B. DATE SIGNED 8-4-68		23C. PHYSICIAN'S NAME (Type) HEWES D. AGNEW MD	
23D. ADDRESS 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug 7, 1968	
24C. NAME OF CEMETERY or CREMATORY Evergreen Memorial Gardens		24D. LOCATION (City, town, or county) (State) Finksburg Md. 21048		25A. DATE REC'D BY HEALTH DEPT. AUG 7 1968	
25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR John E. Jeff		ADDRESS Hampstead, MD 21074	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 8048
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>NETTIE V. WILHELM</b>		2. DATE AND HOUR OF DEATH <b>8-5-68</b> <b>1:50 AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL OF BALTIMORE INC</b> <b>GREENSKING AT BELVEDERE AVE.</b>			C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>FEMALE</b> 6. RACE <b>WHITE</b>			8. DATE OF BIRTH <b>12-19-08</b> 9. AGE (In years lost birthday) <b>79</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		
13. FATHER'S NAME <b>Eli Poe</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>215-07-6654</b>		
17. INFORMANT <b>William Webb</b>			ADDRESS <b>Route 3 Box 136-A Reisterstown, Md.</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>PNEUMONIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>45 IX II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Past- Abdominal Aneurysm Surgery - M.I.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20</b>		
19A. DATE OF OPERATION <b>7-9-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>AORTIC (ABDOM.) ANEURYSM</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7-5</b> 19 <b>68</b> to <b>8-5</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8-5</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Paul D. Krieger MD</b>				23B. DATE SIGNED <b>8-5-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>PAUL D. KRIEGER</b>				23D. ADDRESS <b>c/o Sinai Hosp. of Balt., Balt., Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 8, 1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Park Cem.</b>	
24D. LOCATION (City, town, or county) <b>Woodlawn, Maryland</b>		24E. DATE REC'D BY HEALTH DEPT. <b>AUG 7 1968</b>		24F. NAME OF REGISTRAR <b>Robert E. Jackson</b>	
24G. FUNERAL DIRECTOR <b>W.J. Schuchardt</b>		24H. ADDRESS <b>Owings Mills, Md.</b>		24I. DATE OF DEATH <b>8-5-68</b>	

WHITE WILHELM

3-7-68

3147 CRITTEN TON  
X  
12-11-68  
X  
12-11-68  
X  
12-11-68

Jameson A

12-11-68

7-9-68

7-2-68

Paul D. Krueger  
X  
8-2-68

8-2-68

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8049

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 8049

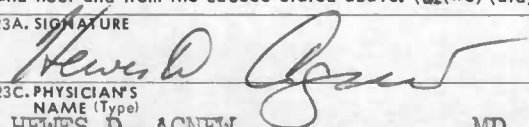
BIRTH NO.		1. NAME OF DECEASED (MARY ANN) (Type or Print) <b>MAE CIESLAK</b>		2. DATE AND HOUR OF DEATH <b>8/4/68 10<sup>10</sup> P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SOUTH BALTIMORE GENERAL HOSPITAL</b> <b>43</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b> C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>1527 RITA ROAD</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/22/24</b>		9. AGE (In years last birthday) <b>44</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE-Waitress, Eastwood Inn</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD. Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>ANTHONY DRANKIEWICZ</b>		
14. MOTHER'S MAIDEN NAME <b>FRANCES JAGIELSKI</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>216-16-5885</b>			17. INFORMANT ADDRESS <b>HOSPITAL RECORD</b>		
18. CAUSE OF DEATH <b>150X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) <b>(A) IMMEDIATE CAUSE CARCINOMA OF ESOPHAGUS, 10 MONTHS DUE TO, OR AS A CONSEQUENCE OF: METASTATIC</b> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>150X II</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7/30</b> 19 <b>68</b> to <b>8/4</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/4</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Herbert E. Mendelsohn M.D.</b>				23B. DATE SIGNED <b>8/4/68</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <b>SOUTH BALTO. GENERAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/8/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Rosary Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 7 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farkas</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>			

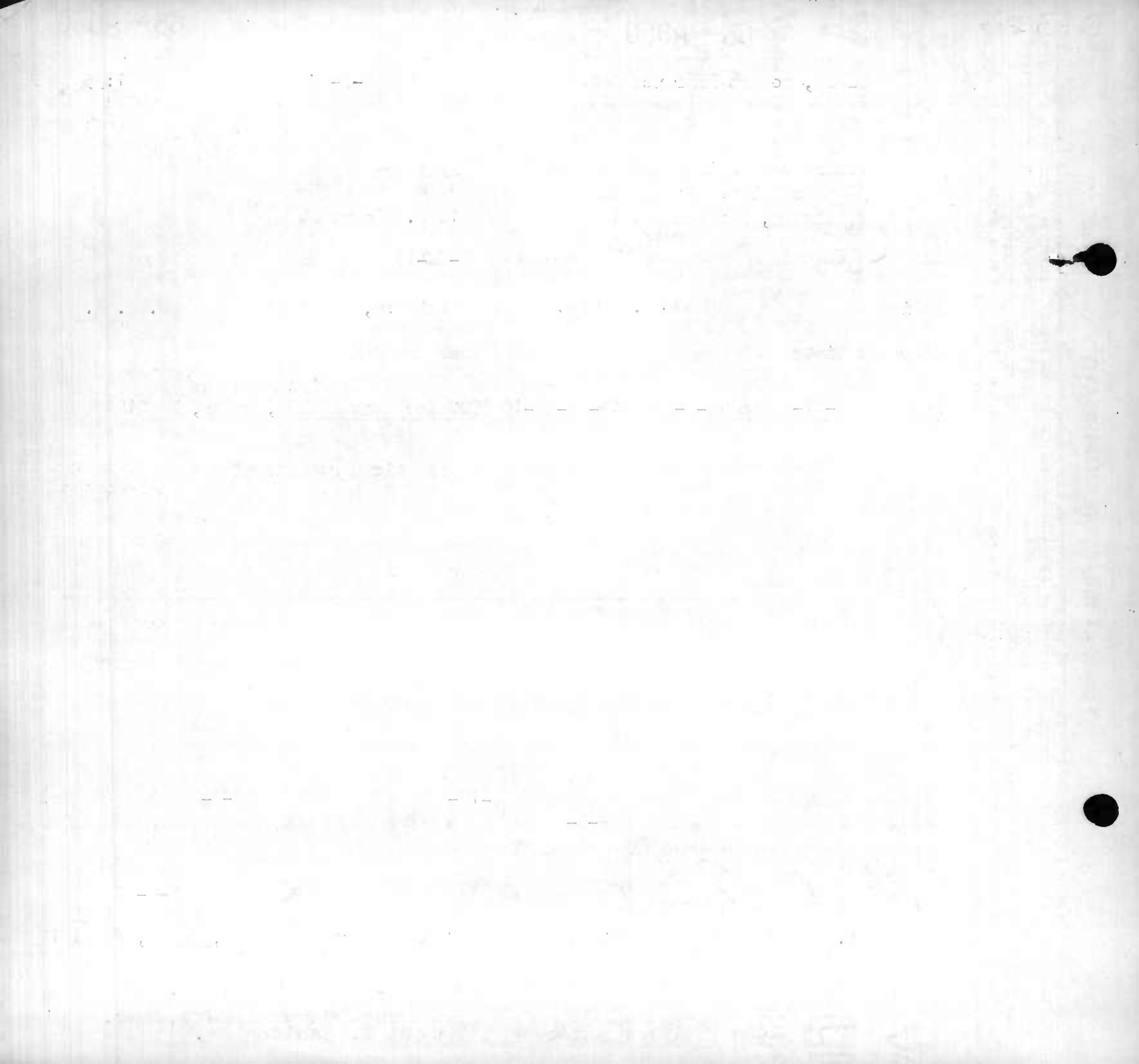


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 68- 8050 CERTIFICATE OF DEATH

REG. NO. 68- 8050

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>DIETZ, Robert Lawrence Sr.</b>		2. DATE AND HOUR OF DEATH <b>8-3-68</b> <b>1:35</b> P.M.																	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY																	
FULL NAME OF HOSPITAL OR INSTITUTION <b>2X Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
				E. STREET AND NUMBER <b>816 N. Glover St</b>																	
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-12-19</b>	9. AGE (In years last birthday) <b>49</b>																
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Policeman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. City.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>																	
13. FATHER'S NAME <b>Lawrence Dietz</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>																	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 4-11-42 to 12-6-45</b>				16. SOCIAL SECURITY NO. <b>218-01-06-10</b>																	
17. INFORMANT <b>VA Hospital Records</b>				ADDRESS <b>3900 Loch Raven Blvd, Balto, Md 21218</b>																	
18. CAUSE OF DEATH																					
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;"> <b>I</b>  <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>Antecedent Causes</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                 </td> <td style="width: 40%;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  <b>Greater than 3 Months</b> </td> </tr> <tr> <td colspan="2"> <b>163X II</b>                      OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                 </td> </tr> </table>						<b>I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>Greater than 3 Months</b>	<b>163X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).													
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<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">19A. DATE OF OPERATION <b>2</b></td> <td style="width: 25%;">19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</td> <td style="width: 25%;">20A. AUTOPSY? (Yes or No) <b>Yes</b></td> <td style="width: 25%;">20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b></td> </tr> <tr> <td colspan="2">21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></td> <td colspan="2">21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</td> </tr> <tr> <td colspan="2">21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</td> <td colspan="2">21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</td> </tr> <tr> <td colspan="2">21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/></td> <td colspan="2">21F. HOW DID INJURY OCCUR?</td> </tr> </table>						19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>																		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)																			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)																			
21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?																			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>7-19-</b> <b>1968</b> to <b>8-3-</b> <b>1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8-3-</b> <b>1968</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. ( <input checked="" type="checkbox"/> (We) (did) ( <del>did not</del> ) view the body after death.																					
23A. SIGNATURE 				23B. DATE SIGNED <b>8-4-68</b>																	
23C. PHYSICIAN'S NAME (Type) <b>HEWES D. AGNEW MD</b>				23D. ADDRESS <b>Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard, Balto, Md 21218</b>																	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/7/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cem.</b>																	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 7 1968</b>																			
25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> <b>2601 E. Madison St.</b>																			



# FUNERAL DIRECTOR: IMPORTANT

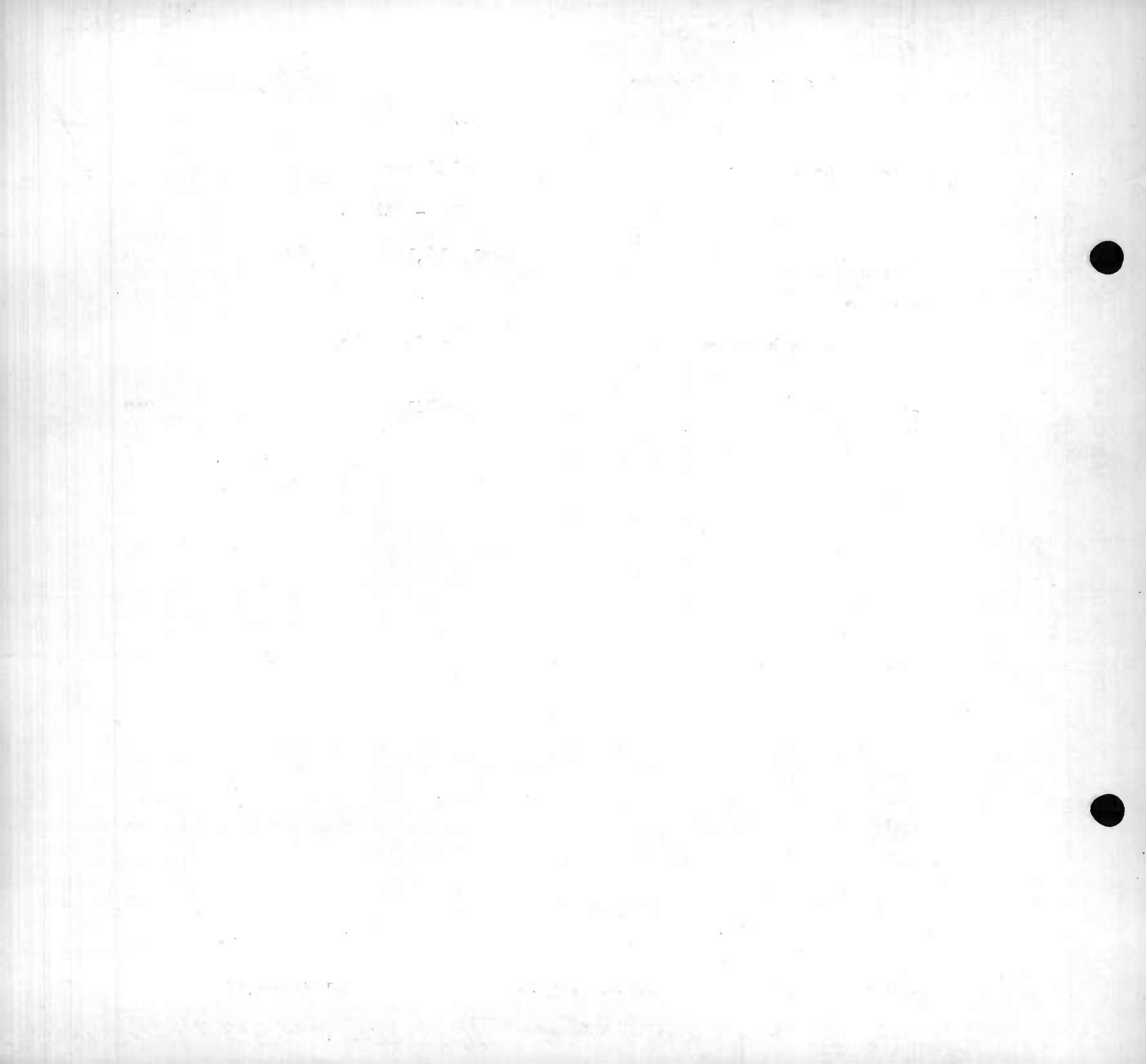
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8051 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO.

68- 8051

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Eleanor N Noethen</b>		2. DATE AND HOUR OF DEATH <b>8/5/68</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md</b> B. COUNTY		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <b>43 So Balto Gen Hosp</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <b>4018 - 8th St</b>			
5. SEX <b>Female</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 16, 1908</b>	9. AGE (In years lost birth day) <b>60</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md</b>	
13. FATHER'S NAME <b>Joseph Brown</b>		14. MOTHER'S MAIDEN NAME <b>Annie Hurley</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Family</b>	
				ADDRESS <b>Same</b>	
18. <b>492X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Emphysema</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pulmonary Emphysema</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
322.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>5</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11-5-1944</b> 19 to <b>8-5-68</b> 19, that (I) (we) last saw the deceased alive on <b>7-27-68</b> 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Harry S. Gimbel</b>		DEGREE Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>8.6.68</b>	
23C. PHYSICIAN'S NAME (Type) <b>HARRY S. GIMBEL</b>		23D. ADDRESS <b>4605 Edmonds Ave</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/8/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cem</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>McCully F.H. 237 Palapso Ave</b>	
				ADDRESS <b>21225</b>	



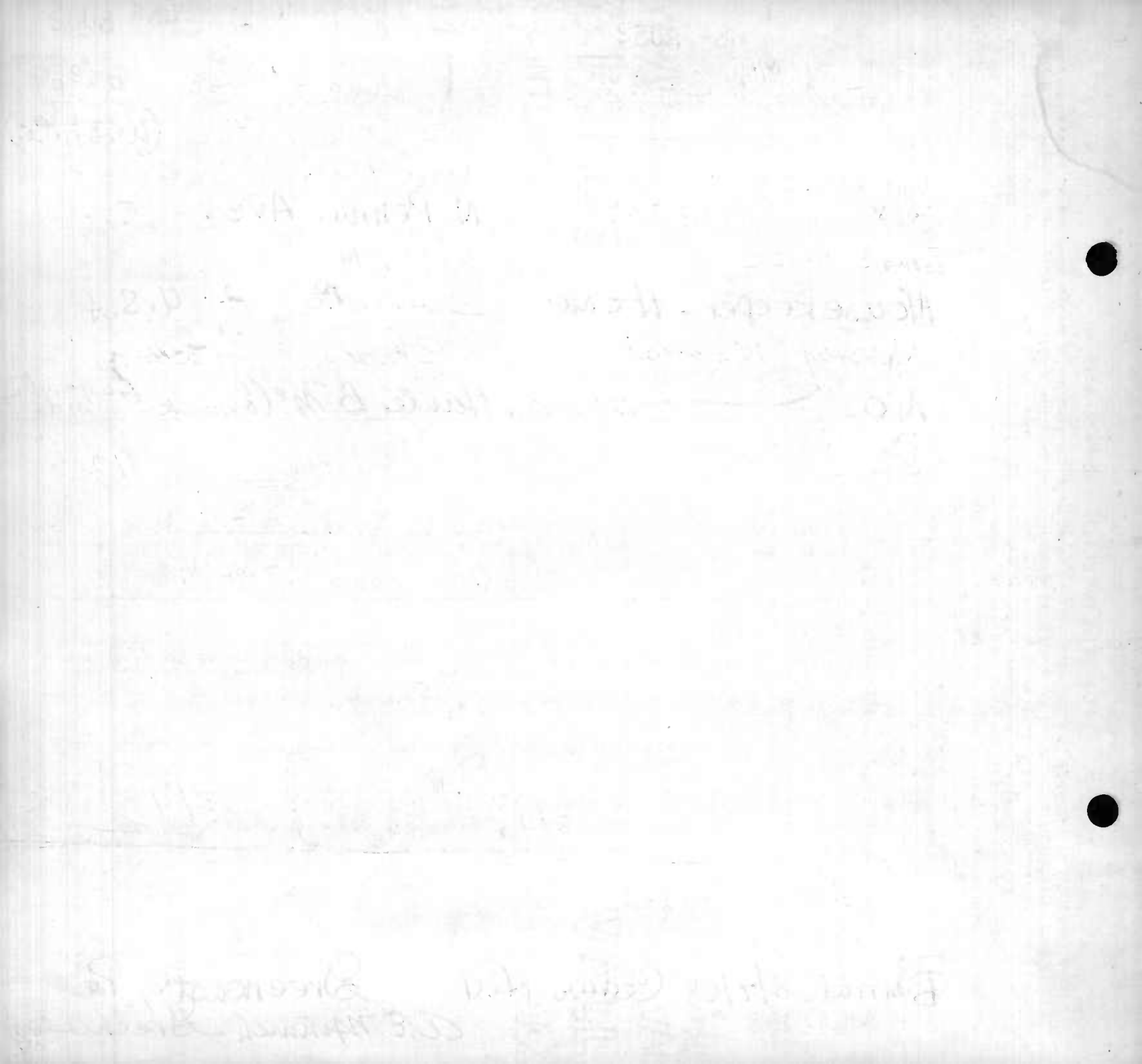
**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

**BALTIMORE CITY HEALTH DEPARTMENT**  
**68- 8052 CERTIFICATE OF DEATH**

REG. NO. **68- 8052**

BIRTH NO. <b>3-265</b>		1. NAME OF DECEASED (Type or Print) <b>Hilda M. McCormick</b>		2. DATE AND HOUR OF DEATH <b>Aug 4 1968 9:30 P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Hagerstown (Wash. Co.)</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>University of Maryland Hospital</b>			C. CITY OR TOWN <b>Hagerstown</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>N. Penna. Ave. 71-03</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/17/1919</b>	9. AGE (In years last birthday) <b>49</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper - Home</b>			11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Harvey Koons</b>			14. MOTHER'S MAIDEN NAME <b>Rhoda Haines</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>207-03-5096</b>		17. INFORMANT <b>Hunter B. McCormick</b> ADDRESS <b>Hagerstown Md.</b>
18. <b>573.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Septic Shock</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Possible Urinary Infection</b> <b>Hepatic coma, GI Bleeding</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Septic Shock</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Possible Urinary Infection</b> (C) <b>Hepatic coma, GI Bleeding</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>22 hr.</b>		
19. <b>583 X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7/31/68</b> to <b>8/4/68</b> that (I) (we) last saw the deceased alive on <b>8/4/68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Edith E. Kemp MD</b>				23B. DATE SIGNED <b>8/4/68</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>8/7/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill</b>	
24D. LOCATION (City, town, or county) (State) <b>Greencastle, Pa.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 7 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Faulkner</b>		25C. FUNERAL DIRECTOR <b>A.E. Minnich - Greencastle</b>			



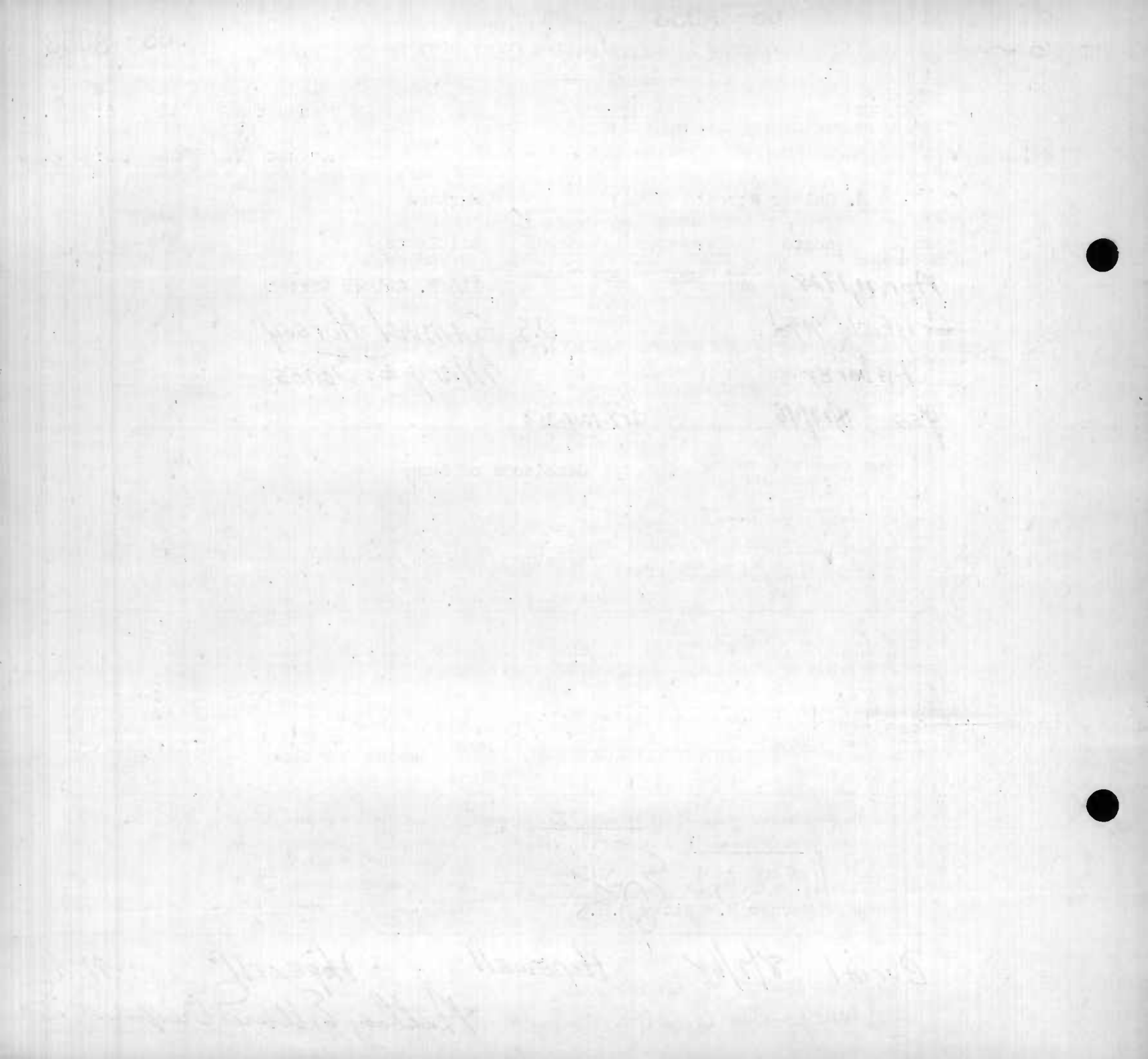
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8053

BIRTH NO.

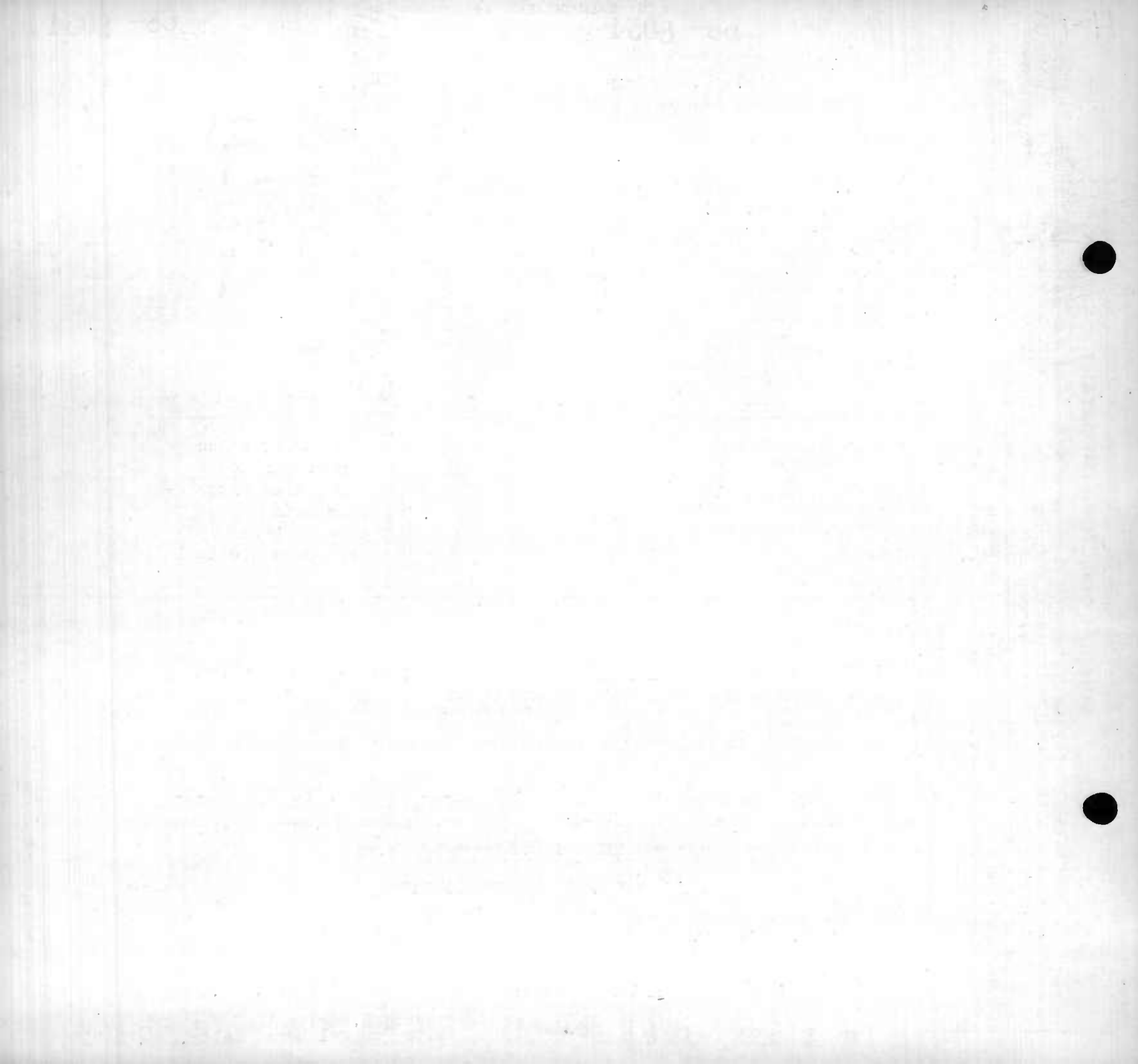
1. NAME OF DECEASED (Type or Print) <b>CALVIN HORSEY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>August 3, 1968</b> 5:00 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>116 N. Culver Street (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 3, 1968 6:35 P.M.</b>	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Apr. 11, 1928</b> 40		E. STREET AND NUMBER <b>116 N. Culver Street</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		15. MOTHER'S MAIDEN NAME <b>MARY E. JONES</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 11/27/46</b>		17. SOCIAL SECURITY NO. <b>217-124-358</b>	
18. INFORMANT <b>1621</b>		ADDRESS	
19. CAUSE OF DEATH <b>1621</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Lung</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/7/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>HOPEWELL</b>		24D. LOCATION (City, town, or county) (State) <b>HOPEWELL Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbanks</b>	
		25C. FUNERAL DIRECTOR <b>Anthony E. Ward Crisfield Md.</b>	
		ADDRESS	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-8054</b>
BIRTH NO.				
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
Elsie M. Hoffman		Aug. 3, 1968 12:30 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  90 Fayette Convalescent Home 1105 E. Fayette Street Baltimore, Md.		A. STATE B. COUNTY		
		Maryland 21225		
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER		
		605 Pontiac Avenue		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Apr. 3, 1894	74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Homemaker		--		Maryland
12. CITIZEN OF WHAT COUNTRY?		USA		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Jacob Keeney		Rebecca E. Young		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS (Son)
No --		218-46-1831		James E. Wiest 521 Chestnut Hill Ave. 21218
18. <b>4339 I</b>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		thrombosis due		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE CVA due to thrombosis to		
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF: generalized arterio-sclerosis		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) chronic brain syndrome due to 1.		
		(C) _____		
19. <b>332X II</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0	-----	No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?		
(Month) (Day) (Year) (Hour)	While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11-3- to 19 66 to 8-3- 19 68, that (I) (we) last saw the deceased alive on 8-3-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
<i>E. Ellsworth Cook</i>		8-3-68		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
E. Ellsworth Cook		2431 Maryland Avenue		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)	
Burial	8/6/68	Oaklawn Cemetery	Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS		
AUG 7 1968	<i>R. E. F. J. J.</i>	Eugenia K. Seitz 5209 York Rd. Seitz Funeral Home Balto. Md. 21212		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT			
68- 8055		CERTIFICATE OF DEATH	
BIRTH NO.		REG. NO. 68- 8055	
1. NAME OF DECEASED (Type or Print) <b>JAMES E. SEATON, JR.</b>		2. DATE AND HOUR OF DEATH <b>8/5/68</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>md</b> B. COUNTY <b>14-02</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b> <b>1531 Druid Hill Ave</b>		C. CITY OR TOWN <b>Balto</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>1531 Druid Hill Ave</b>			
5. SEX <b>m</b>	6. RACE <b>negr</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 27-1900</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Post office</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Post office</b>	
11. BIRTH PLACE (State or foreign country) <b>Baltimore Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>67</b>	
13. FATHER'S NAME <b>James Edward Seaton</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Ellen Johnson</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <b>yes world war 1</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Corinne Seaton</b>		ADDRESS <b>1531 Druid Hill</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>733.1</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Cerebral Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>332 X II</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>7</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>June 3 1968</b> to <b>Aug 5 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 5 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <b>F. K. Adams</b>		23B. DATE SIGNED <b>8-6-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>F. K. ADAMS</b>		23D. ADDRESS <b>1222 N. Caroline St Baltimore Md 21213</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/9/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Balto. National</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>	
25C. FUNERAL DIRECTOR <b>Wm. J. Chatman, Jr.</b>		ADDRESS <b>1701 Mt. Calvary St</b>	

1897-1898  
Baltimore  
English  
German  
Italian

James  
1897-1898

1897-1898  
Italian

at

1897-1898  
at

1897-1898  
at

F. K. ADAMS  
F. K. Williams

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8056 CERTIFICATE OF DEATH

REG. NO. 68- 8056

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ADAM F. DRAPER</b>		2. DATE AND HOUR OF DEATH <b>AUGUST 2 1968 11:45 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1-03</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>529 S. LAKEWOOD AVE.</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>529 S. LAKEWOOD AVE.</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 2, 1898</b>	9. AGE (In years last birthday) <b>69 YRS.</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR RET.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>TAXI</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>ALEXANDER DRAPER</b>		14. MOTHER'S MAIDEN NAME <b>MARYANNA ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-01-0573</b>		17. INFORMANT <b>MARIE DRAPER</b>	
18. CAUSE OF DEATH <b>1519 I</b>		ADDRESS <b>529 S. LAKEWOOD AVE.</b>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CANCER OF STOMACH</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2-3 MOS</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>13-1X II</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>2/12</b> 19 <b>68</b> to <b>8/2</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/2</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did) (did not) view the body after death.					
23A. SIGNATURE <b>Benjamin H. Hirstein</b>		23B. DATE SIGNED <b>8/5/68</b>			
23C. PHYSICIAN'S NAME (Type) <b>DR. B. H. HIRSTEIN</b>		23D. ADDRESS <b>121 S. HIGHLAND AVE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/6/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy ROSARY CEMETERY</b>	
24D. LOCATION <b>BALTIMORE MARYLAND</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>RAYMOND L. KACZOROWSKI</b>	
25D. ADDRESS <b>2525 FLEET ST.</b>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 68- 8057 CERTIFICATE OF DEATH

REG. NO. 68- 8057

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

TROCKE, Mrs ANIELA

2. DATE AND HOUR OF DEATH

31st July 1968 12:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

CHURCH HOME AND HOSPITAL  
100 N. BROADWAY  
BALTIMORE MD. 21231

4. USUAL RESIDENCE (Where deceased lived If institution: residence before admission)

A. STATE

B. COUNTY

MD

Balt

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

6910 CONLEY ST. 21224.

5. SEX

F

6. RACE

W

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

9-25-88

9. AGE (in years last birthday)

79

11. Under 1 Yr. Months: Days:

if Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

POLAND

12. CITIZEN OF WHAT COUNTRY?

AMER.

13. FATHER'S NAME

JOHN WIDOMSKI

14. MOTHER'S MAIDEN NAME

—

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

215 09 3357

17. INFORMANT

DR. V. GANGADHARAN MD

ADDRESS

100 N Broadway  
21231 Baltimore MD

18. 412.21

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Electrolyte Imbalance  
Hypertensive Cardiovascular Disease - congestive Heart Failure

2 days

Not known

(B) DUE TO, OR AS A CONSEQUENCE OF:

Pneumonia Bilateral

Days

(C) DUE TO, OR AS A CONSEQUENCE OF:

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At ☐ Not White At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7-28 - 1968 to 7-31 - 1968, that (I) (we) lost saw the deceased alive on 7-31 - 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Cezar G. Lopez MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

7-31-1968

23C. PHYSICIAN'S NAME (Type)

CEZAR A. LOPEZ MD

23D. ADDRESS

100 N Broadway Church Home and Hosp Baltimore MD 21231

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

8/3/68

24C. NAME OF CEMETERY or CREMATORY

Holy Redeemer Cem.

24D. LOCATION

BALTIMORE MD.

25A. DATE REC'D BY HEALTH DEPT.

AUG 7 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

RAYMOND L. KACZOROWSKI 2525 FLEET ST.

James L. K...  
K... Co. Baltimore, Md.

100 H...  
Baltimore, Md. 21201

7-31-76  
7-28-76  
7-27-76

James L. K...  
Baltimore, Md.  
Baltimore, Md.

212 09 101 26 V (Baltimore, Md.)

John W...  
Baltimore, Md.

100 H...  
Baltimore, Md.  
Baltimore, Md.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 8058

BIRTH NO.

REG. NO.

## 1. NAME OF DECEASED

(Type or Print)

ROBERT

DUKEHART

2. DATE  
OF  
DEATHKnown ☐ Estimated ☒

Month

Day

Year

Hour

August 4, 1968

1:40 AM

## 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

St. Agnes Hospital (DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

August 4, 1968

1:40 AM

## 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

## C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Catonsville

Baltimore, Co

YES ☐NO ☒

## 6. SEX

male

## 7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

## 9. DATE OF BIRTH

May 24, 1949

10. AGE (In years  
last birthday)

19

## 11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A

## E. STREET AND NUMBER

8 N. Beechwood Road

## 13. FATHER'S NAME

Charles J. Dukehart

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Janitor work

## 14B. KIND OF BUSINESS OR INDUSTRY

Restaurant

## 15. MOTHER'S MAIDEN NAME

Virginia E. Deering

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Army reserves

17. SOCIAL  
SECURITY NO.

214-50-8826

## 18. INFORMANT

Mr. Charles J. Dukehart

## ADDRESS

1835 Frederick Rd. Catonsville, Md.  
2122819. *E 816.0*

## CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Multiple Injuries

## (A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## (B)

DUE TO, OR AS A CONSEQUENCE OF:

## (C)

MEDICAL CERTIFICATION

*E 823 X* II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

## 20A. DATE OF OPERATION

## 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

## 21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Rte. 40 and Johnnycake Road

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

8/4/68 1:05 A.

## 22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

## 22F. HOW DID INJURY OCCUR?

subj. driver, failed  
to negotiate turn, struck telephone pole

## 23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/4/68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

## 24B. DATE

8/6/1968

## 24C. NAME OF CEMETERY or CREMATORY

New Cathedral Cemetery

## 24D. LOCATION (City, town, or county)

Baltimore, Md.

## 25A. DATE RECEIVED BY HEALTH DEPT.

AUG 7 1968

## 25B. NAME OF REGISTRAR

Robert E. Fairley, M.D.

## 25C. FUNERAL DIRECTOR

Easton Funeral Home Catonsville, Md.

## ADDRESS

1



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8059

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 8059

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

K. Leroy Yingling

Kenneth LeRoy Yingling

2. DATE AND HOUR OF DEATH

8-3-68

4:45 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44

Union Memorial Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2810 Rosalie Ave

5. SEX

Male

6. RACE

White

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

2-21-11

9. AGE (In years last birthday)

57

If Under 1 Yr. Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

America

13. FATHER'S NAME

Edward Yingling

14. MOTHER'S MAIDEN NAME

Agatha Mathias

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

213-01-3339

17. INFORMANT

Catherine E. Yingling-2810 Rosalie Ave. 21234

18. 410.9 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Myocardial Infarction

(B)

DUE TO, OR AS A CONSEQUENCE OF:

ARTERIOSCLEROTIC CARDIOMYOPATHY

(C)

C.S.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 7-31-1968 to 8-3-1968, that (I) (we) last saw the deceased alive on 8-3-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Stephen Goldberger M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED

8-3-68

23C. PHYSICIAN'S NAME (Type)

STEPHEN GOLDBERGER, M. D.

23D. ADDRESS

THE UNION MEMORIAL HOSPITAL 2810 Rosalie Ave. Baltimore, Md. 21209

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/7/68

24C. NAME of CEMETERY or CREMATORY

Baltimore Cemetery

24D. LOCATION

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 7 1968

25B. NAME OF REGISTRAR

Robert E. Fairbank

25C. FUNERAL DIRECTOR

Robert C. Altenburg Funeral Home, Inc. 6009 Harford Rd. - Balto., Md. 21214

Edward Young

Marland

Baltimore

2810 Rosalie Ave

3-21-11 21

Marland

Edward Young

Male White

Seamen

Edward Young

Marland

2810 Rosalie Ave

3-21-11

21

3-21-11 21

8-3

John Young

8-3

2810

FUNERAL DIRECTOR: IMPORTANT

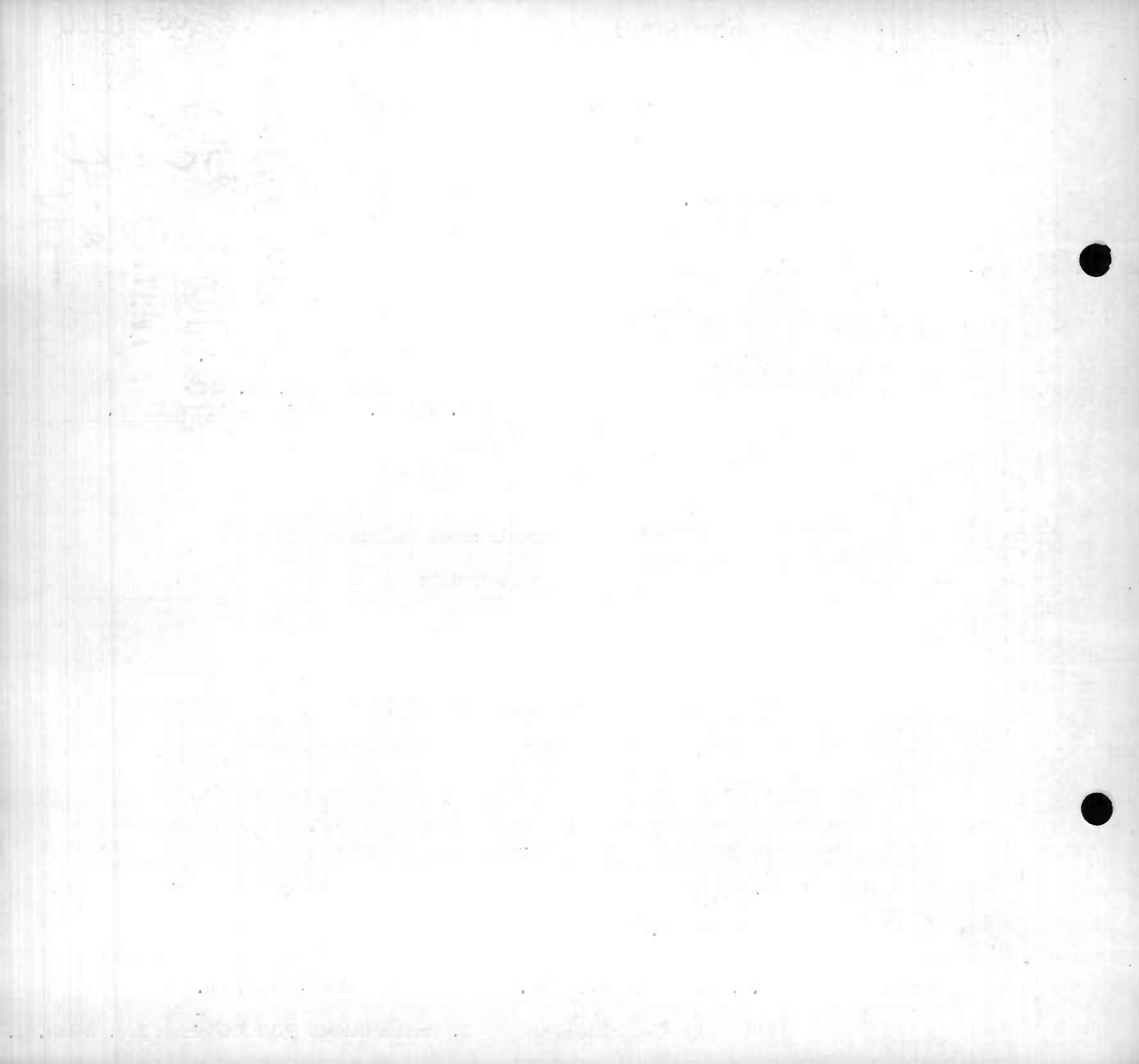
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8060

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 8060

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mr. William Flint</i>		2. DATE AND HOUR OF DEATH <i>8.1.1968 3.15 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Balto. Md.</i> B. COUNTY <i>U.S.A.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>34 Bon Secours Hosp.</i>		C. CITY OR TOWN <i>Balto. Md.</i>		D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>242 Mallow Hill Rd</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/6/1927</i>	9. AGE (In years last birthday) <i>74</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Maintenance</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Balto. Stock Exchange</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>James Flint</i>		14. MOTHER'S MAIDEN NAME <i>Popp Mary B.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-05-8229</i>		17. INFORMANT ADDRESS <i>Catonsville, Md. 24229</i> <i>Mrs. Ella L. Flint 242 Mallow Hill Rd.</i>	
18. <i>590.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Urinemia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(B) <i>Chronic Renal Failure</i> DUE TO, OR AS A CONSEQUENCE OF:		(C) <i>Byemonephritis</i>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>600.0 II</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7-9</i> 19 <i>68</i> to <i>8-1</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>8-1</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>M. Keyhani</i>		23B. PHYSICIAN'S NAME (Type) <i>M. KEYHANI</i>		23C. ADDRESS <i>Glen Haven Cem.</i>	
23D. DATE SIGNED <i>8.1.1968</i>		23E. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Aug. 5, 1968</i>		24C. NAME OF CEMETERY or CREMATORY <i>Glen Haven Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Glen Burnie, Md.</i>		24E. DATE REC'D BY HEALTH DEPT. <i>AUG 7 1968</i>		24F. NAME OF REGISTRAR <i>Robert E. Feltner</i>	
24G. FUNERAL DIRECTOR <i>G. Truman Schwab</i>		24H. ADDRESS <i>3512 Frederick Ave. Balto. Md.</i>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8061 CERTIFICATE OF DEATH

REG. NO. 68- 8061

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

SHABELSKI, Adam (NMI)

2. DATE AND HOUR OF DEATH

8-4-68

4:05 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  
 23 Veterans Administration Hospital  
 3900 Loch Raven Blvd  
 Baltimore, Maryland 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

317 W. 29th Street

5. SEX

Male

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

5-15-02

9. AGE (In years lost birthday)

66

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Accountant

10B. KIND OF BUSINESS OR INDUSTRY

Unknown

11. BIRTHPLACE (State or foreign country)

Warsaw, Poland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Fransiz Shabelski

14. MOTHER'S MAIDEN NAME

Marvina Kiminski

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

11-12-42 to 6-15-45

16. SOCIAL SECURITY NO.

060-10-3596

17. INFORMANT

Records  
VAH, Balto., Md. 21218

ADDRESS

18.

571.0 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

Liver Cirrhosis

DUE TO, OR AS A CONSEQUENCE OF:

(B)

Chronic Alcoholism

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3 Years

MEDICAL CERTIFICATION

581.1 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that 1 (this hospital) attended the deceased from 6-6-68 19 68 to 8-4 19 68, that 25 (we) last saw the deceased alive on 8-4 19 68 and that in 26 (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) 100000 view the body after death.

23A. SIGNATURE

R. A. Hovhannessian

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

8-5-68

23C. PHYSICIAN'S NAME (Type)

Raffy A. Hovhannessian

23D. ADDRESS

3900 Loch Raven Blvd., Balto., Md. 21218

24A. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24B. DATE

8-5-68

24C. NAME OF CEMETERY or CREMATORY

Manatoba Cemetery

24D. LOCATION (City, town, or county)

Manatoba, Canada

25A. DATE REC'D BY HEALTH DEPT.

AUG 7 1968

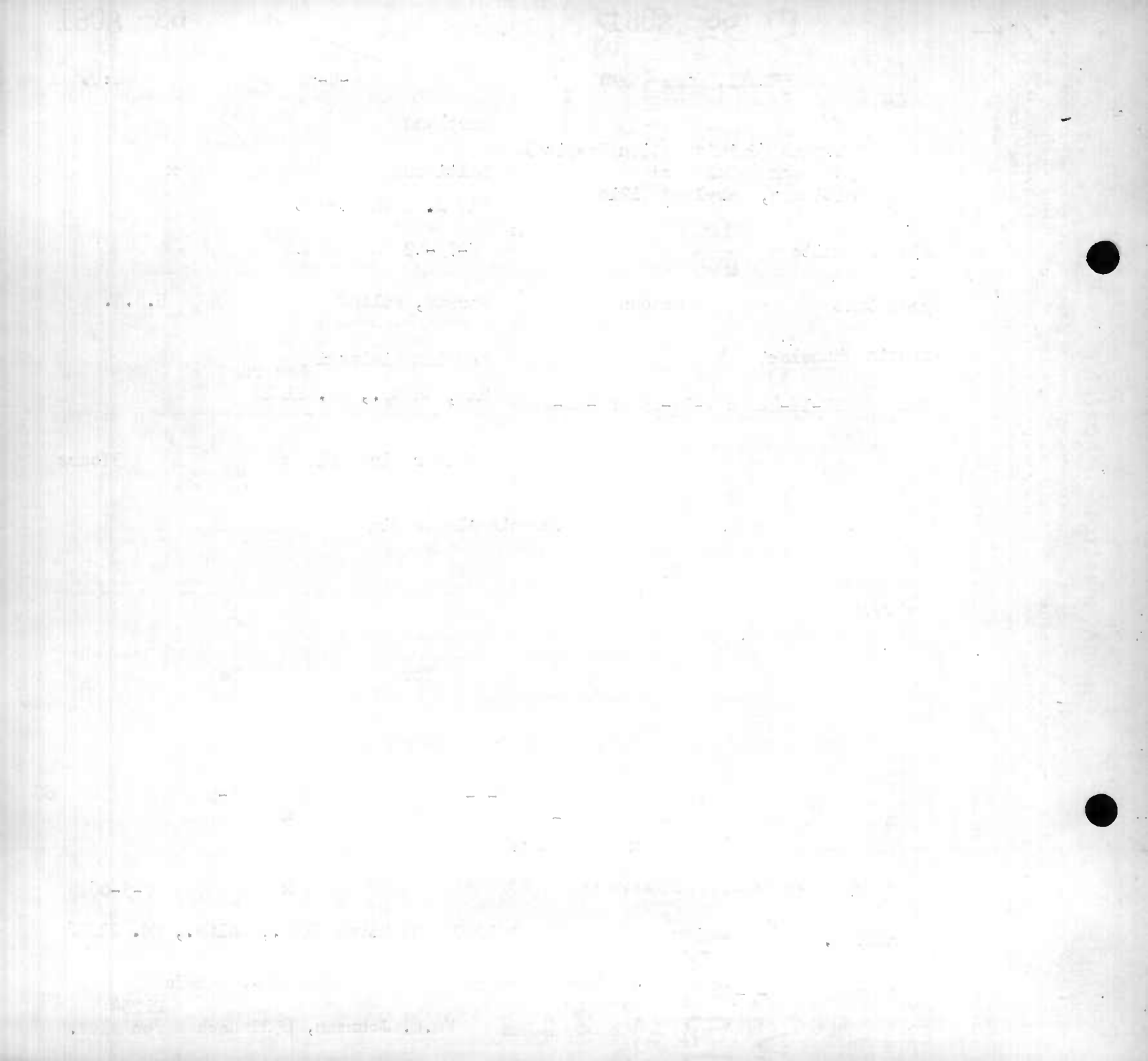
25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

Wm. E. Johnson, 8521 Loch Raven Blvd.

21204 ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-8062
BIRTH NO. 68-8062		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Thompson, Mabel L.</u>		2. DATE AND HOUR OF DEATH <u>August 3, 1968</u> <u>5:18</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hospital.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland.</u> B. COUNTY <u>Howard Co.</u> C. CITY OR TOWN <u>Savage.</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>Box 294.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>09-27-40</u>	9. AGE (in years last birthday) <u>27</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Earl Campbell</u>		
14. MOTHER'S MAIDEN NAME <u>Mabel Campbell</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unk.</u>		
16. SOCIAL SECURITY NO. <u>49-35-99</u>		17. INFORMANT <u>Patient &amp; old chart</u>		
18. <u>571.8</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Exsanguination</u> <u>hepatic failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Post Necrotic Cerebri</u> <u>chronic relapsing hepatitis C.S.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs</u> <u>5-10 yrs</u>		
19. <u>581.0</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>None</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <u>No</u>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>No</u>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>No</u>		
21D. TIME OF INJURY (APPROX.) <u>No</u>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>No</u>		
22. I certify that (I) (this hospital) attended the deceased from <u>July 1st</u> 19 <u>68</u> to <u>Aug 3</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Aug 3</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.				
23A. SIGNATURE <u>Brian Block MD</u>		23B. DATE SIGNED <u>Aug 3 1968</u>		23C. PHYSICIAN'S NAME (Do not print) <u>BRIAN BLOCK</u>
23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>8-6-68</u>	24C. NAME OF CEMETERY or CREMATORY <u>Deerfield Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Malta Ohio</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 7 1968</u>	25B. NAME OF REGISTRAR <u>Robert E. Feltman</u>	25C. FUNERAL DIRECTOR <u>Jeffrey E. Davidson, Funeral Dir.</u>		

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-8063

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68-8063

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Hattie Wright		Aug 5, 1968 7:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Kenson Nursing Home 2922 Arunah Ave.		Maryland		B. COUNTY	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore,		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER		516 Fremont Ave.	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Female	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 9, 1888	80	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Thomas Rice		Gracie Johnson		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Lester Rice 1006 Arlington Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Cardio-vascular disease months	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
422.1 II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0 none				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Aug 3, 1968 to Aug 5, 1968, that (I) (we) last saw the deceased alive on Aug 5, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Frank N. Ogden, M.D.				AUG. 6, 1968	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
FRANK N. OGDEN, M.D.				2701 N. Calvert St. Balto. Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/8/68		Mt Auburn	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 7 1968		Robert E. Fairburn		Kelson Funeral Home 1348 Calhoun St.	

George Washington

MC

July 27 1792

Thomas M. Gordon, M.D.

FRANK L. BROWN, M.D.

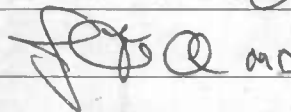
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 8064 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

DR. C. HARRIS 68-8064  
REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CONTEE, EARL LOUIS</b>		2. DATE AND HOUR OF DEATH <b>8-5-68</b> <b>9:32 PM</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
5. SEX <b>M</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-20-11</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DAVIDSON CLOTHING</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Curtis Bay, MD</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>SPENCER</b>		
14. MOTHER'S MAIDEN NAME <b>ROSIE SNAIL</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>unk</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>WIFE</b> <b>1153 WHATCOAT BALTO.</b>		
18. <b>157.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CA OF PANCREAS</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6-20 Gals</b>		
19A. DATE OF OPERATION <b>1-24-68</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>tissue diagnosis</b>		
20A. AUTOPSY? (Yes or No) <b>NO</b>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7-3-68</b> 19 to <b>8-5-68</b> 19, that (I) (we) last saw the deceased alive on <b>8-5-68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED <b>8-5-68</b>		23C. PHYSICIAN'S NAME (Type) <b>University Hospital</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/10/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 7 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fairly</b>		25C. FUNERAL DIRECTOR <b>Kelson Funeral Home</b>			
25D. ADDRESS <b>1348 Calhoun St.</b>					

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8065

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MILTON C. PAIGE

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

August 6, 1968

6:10 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
HOSPITAL ADDRESS OR LOCATION)  
OR INSTITUTION

001028 Argyle Avenue

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

August 6, 1968

6:10 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☒NO ☐

6. SEX

male

7. RACE

negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

10. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

Jun. 12, 1920 48

E. STREET AND NUMBER

1028 Argyle Avenue

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A

13. FATHER'S NAME

Oscar Paige

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Oper. Rm. Tech.

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Lillie Robinson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Alice Paige 1028 Argyle Ave.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Intracerebral and Subarachnoid Hemorrhage

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/6/68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8/9/68

24C. NAME OF CEMETERY or CREMATORY

Balto. National

24D. LOCATION (City, town, or county)

Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

AUG 7 1968

R. E. Spitz

Kelson Funeral Home 1348 Calhoun St



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

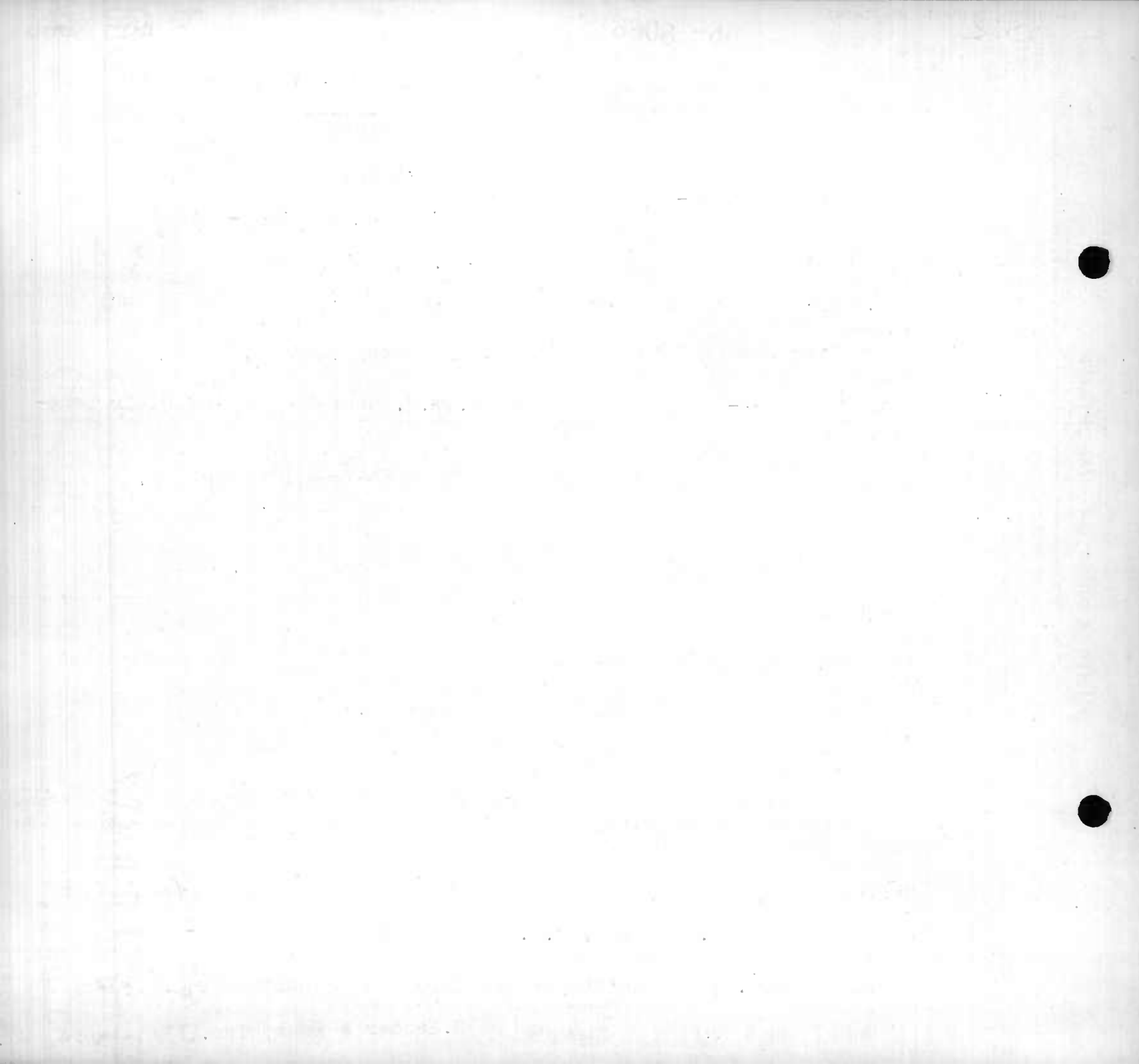
68- 8066

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 8066

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ALMIRA EDNA ADAMS		August 5, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland			
925 Quantrill Way - 21205		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 925 Quantrill Way - 21205			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 29, 1887	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME William Joseph Coburn		12. CITIZEN OF WHAT COUNTRY? USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mr. Wm. J. Adams-7935 Saint Clair Lane-	
18. 428X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.2 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 5 1968 to Aug 5 1968, that (I) (we) last saw the deceased alive on Aug 5 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George E. Shannon				23B. DATE SIGNED Aug 6 1968	
23C. PHYSICIAN'S NAME (Type) George E. Shannon, M.D.				23D. ADDRESS Medical Arts Bldg - 21201	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 8, 68		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1968		25B. NAME OF REGISTRAR Robert E. Finkema		25C. FUNERAL DIRECTOR ADDRESS H. Sander & Sons, Inc., Baltimore, Md.	



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68- 8067 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 8067

BIRTH NO. 68-13960

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>LOUIS RALPH SAGHY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 8 7 68 8:50 a M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 427 S. Pulaski St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 7 1968 8:50 a M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
9. DATE OF BIRTH <b>July 16 - 1968</b>		10. AGE (In years lost birthday) <b>3 wks</b>	
11. BIRTH PLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
15. FATHER'S NAME <b>Louis Ralph Saghy Sr</b>		15. MOTHER'S MAIDEN NAME <b>Constance Louise Simmot</b>	
18. INFORMANT <b>Mrs Louis R Saghy Jr</b>		ADDRESS	
19. <b>590.1</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Acute pyelonephritis</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
20. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL (CREMATION, REMOVAL) (Specify) <b>Burial</b>		24B. DATE <b>Aug 5 - 1968</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill Cem</b>		24D. LOCATION (City, town, or county) (State) <b>AA Co</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr</b>	
25C. FUNERAL DIRECTOR <b>Francis Miller 2101 Frederick Ave</b>			

18-8083

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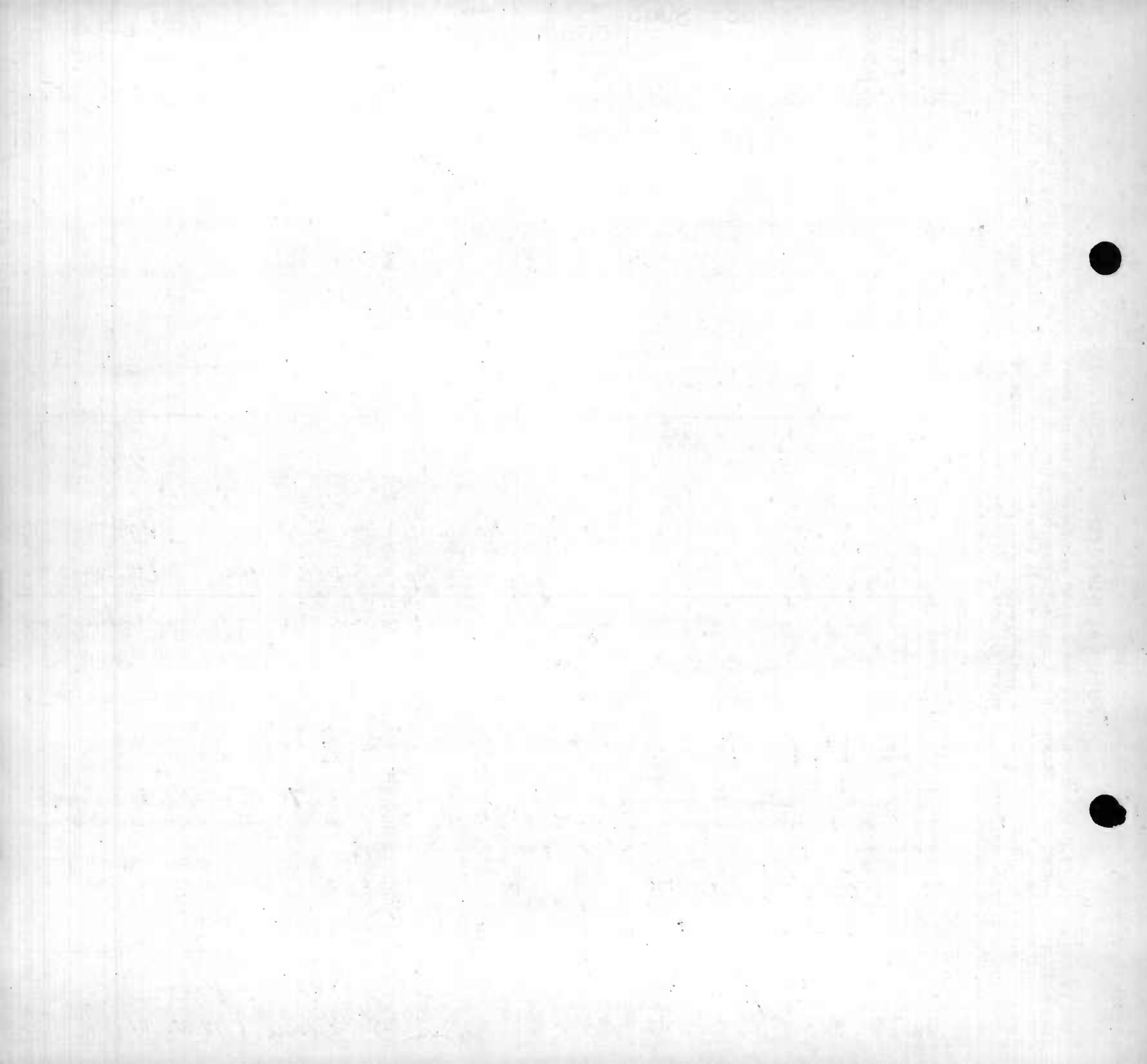
18-8083

18-8083

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-8068	
<div style="display: flex; justify-content: space-between;"> <span>5-354</span> <span>68-8068</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print) <u>George Stanley</u>			2. DATE AND HOUR OF DEATH <u>7-28-1968</u> <u>4:15</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>George Washington NURS. Home</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>106 Fremont AVE</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-15-83</u>	9. AGE (In years last birthday) <u>84</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshore</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Robert Stanley</u>			14. MOTHER'S MAIDEN NAME <u>HANAWA</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-07-5068</u>		17. INFORMANT <u>Chart #752, 607 Penna AVE.</u>	
18. <u>412.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
(B) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF:				Unknown	
(C) <u>Chronic Brain Syndrome</u>				Unknown	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Gen. Arteriosclerosis</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 6, 1967</u> to <u>July 28, 1968</u> , that (I) (we) last saw the deceased alive on <u>July 18, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E. E. Holt, M.D.</u>				23B. DATE SIGNED <u>7/30/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>E. E. Holt M.D.</u>				23D. ADDRESS <u>3715 Liberty Hts. Ave. Baltimore, Md. 21215</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>8/3/1968</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 7 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>John T. Small 1712 W. North Ave</u>	



THE BODY OF PEARL SCOTT HAS BEEN RELEASED ON APPROVAL BY DR KORNBLUM  
OF THE MEDICAL EXAMINER'S OFFICE  
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released ON APPROVAL for the Med. Examiner's office by Dr. Kornblum per Mr. Gregory

BIRTH NO. 5-300		68-8069		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-8069	
1. NAME OF DECEASED (Type or Print) PEARL SCOTT				2. DATE AND HOUR OF DEATH AUGUST 2, 1968 2:15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 The Johns Hopkins Hospital				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE Negroid		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH -02-1928	
9. AGE (In years last birthday) 40		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Leighton				14. MOTHER'S MAIDEN NAME Mary Simms			
15. Was Deceased Ever in U. S. Armed Forces? (Yes no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mary Simms 3619 Forrest Park Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 307 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 2				CAUSE OF DEATH Lobar Pneumonia (A) IMMEDIATE CAUSE - Chronic Alcoholism & D.T.'s (B) DUE TO, OR AS A CONSEQUENCE OF: Pneumonia, D.T.'s (chronic alcoholism) (C) DUE TO, OR AS A CONSEQUENCE OF: peripneumonic APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 AM - 2:15 PM Pneumonia acute onset chronic alcoh.			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (his hospital) attended the deceased from July 31 1968 to August 2 1968, that (I) (we) last saw the deceased alive on August 2 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. D. Hank Jr. M.D.				23B. DATE SIGNED August 8/2/68		23C. PHYSICIAN'S NAME (Type) EDWARD D. HANK JR.	
23D. ADDRESS 1519 E. Monument St. Baltimore, Md.				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 8-6-68		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) Baltimore, Md.		24E. STATE	
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Rayner Sanders		25D. ADDRESS 217 E. Preston St.	

27.5

1000 ft

1000 ft

1000 ft

1000 ft

1000 ft

1000 ft

1000 ft

1000 ft

**FUNERAL DIRECTOR: IMPORTANT**

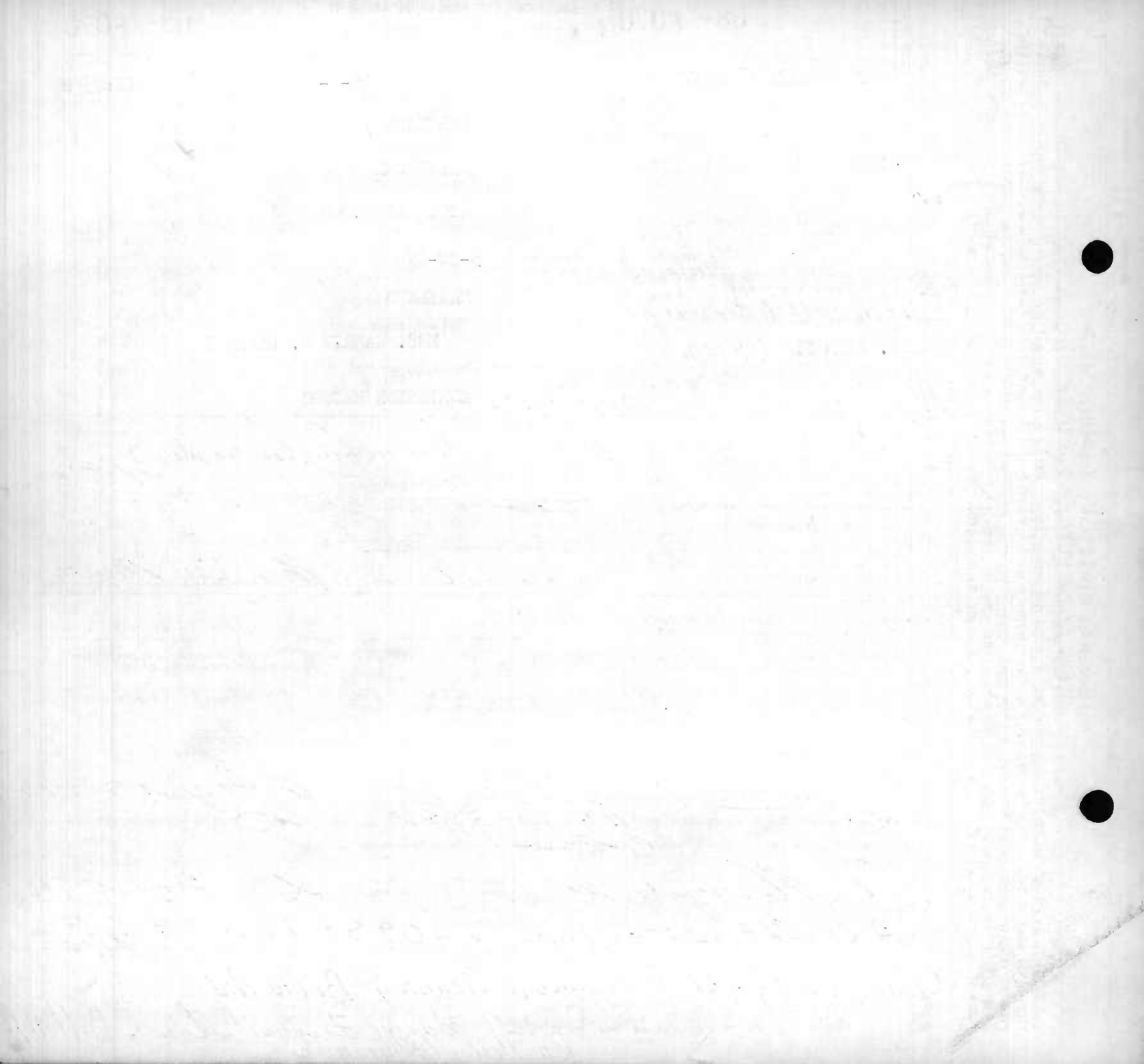
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8070

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

REG. NO. 68- 8070

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARGHERITA H SWANN</b>		2. DATE AND HOUR OF DEATH <b>8-3-68</b> <b>11:05 P</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BOLTON HILL NURSING CENTER</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
				C. CITY OR TOWN <b>BALTIMORE</b>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>4201 LINKWOOD Rd</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-30-89</b>	9. AGE (In years last birthday) <b>79</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Editorial Writer News paper</b>				11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>DR. HARRELL (Francis)</b>				14. MOTHER'S MAIDEN NAME <b>MRS. CARRIE E. BALLAGH</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216 093425A</b>		17. INFORMANT <b>ADMISSION RECORD</b>	
18. CAUSE OF DEATH <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Atherosclerotic Cardiovascular Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(B) Due to OR AS A CONSEQUENCE OF:</b> <b>(C) Brain Cerebral Thrombosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>422.1 II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(A)</u> (this hospital) attended the deceased from <u>May 25</u> 19 <u>68</u> to <u>August 3</u> 19 <u>68</u> , that <u>(B)</u> (we) lost saw the deceased alive on <u>August 3</u> 19 <u>68</u> and that in <u>(C)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(D)</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>H. C. Alvarez MD</b>				23B. DATE SIGNED <b>August 3, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>H. C. ALVAREZ MD</b>				23D. ADDRESS <b>1209 St Paul St, Baltimore</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>5 Aug 68</b>		24C. NAME of CEMETERY or CREMATORY <b>Greenmount Crematory</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 7 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Burpee Funeral Home Balto Md</b>			
25D. ADDRESS <b>Bq North Mt Vernon St</b>					



1  
A-35-2

68- 8071 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 68- 8071

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Nora Elizabeth/Adams</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>8</b> Day <b>3</b> Year <b>68</b> Hour <b>2:25</b> A.M. Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>8</b> Day <b>3</b> Year <b>68</b> Hour <b>2:25</b> A.M.	
6. SEX <b>F</b>		7. RACE <b>W</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Salisbury</b>	
9. DATE OF BIRTH <b>Oct. 25, 1915</b>		10. AGE (In years lost birthday) <b>52</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Presser</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT (Husband) <b>Mr. Sidney Adams, Salisbury, Maryland</b>		ADDRESS <b>205 Walnut St.</b>	
19. <b>431.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Massive intracerebral hemorrhage, spontaneous</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 6, 1968</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Wicomico Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Salisbury, Wicomico, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		DATE SIGNED <b>Aug. 3, 1968</b>	

08-6072

08-6072 X

Ernest Hornsman

USA

1912

White White

Laundry

Ernest

Ernest Adams, 241

no

WALL STREET

VALLEY

Palisades, New York

1912

RAILWAY & COMPANY

1912

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8072

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIE MAE RHODES</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>August 6, 1968 1:40 A.M.</b>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1140 Argyle Avenue</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 6, 1968 1:40 A.M.</b>			
6. SEX <b>female</b>				7. RACE <b>negro</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>1-3-1918</b>				10. AGE (In years last birthday) <b>50</b>		11. BIRTHPLACE (State or foreign country) <b>Akron, Ohio</b>	
12. CITIZEN OF <b>U.S.A.</b>				13. FATHER'S NAME <b>UNK.</b>		14. MOTHER'S MAIDEN NAME <b>OTHA JACKSON</b>	
15. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b>				B. COUNTY <b>Baltimore</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.			
18. INFORMANT <b>Mr. Thomas Rhodes</b>				ADDRESS <b>1140 Argyle Avenue</b>			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Carcinoma of Breast</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) DUE TO, OR AS A CONSEQUENCE OF:			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				22. AUTOPSY? (Yes or No) <b>No</b>			
23. DATE OF OPERATION				24. CONDITION FOR WHICH OPERATION WAS PERFORMED			
25. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
27. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				28. HOW DID INJURY OCCUR?			
29. TIME OF INJURY (APPROX.)				30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
31. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				32. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
33. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				34. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
35. ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>				36. DATE SIGNED <b>8/6/68</b>			
37. EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>				38. DATE <b>8-10-68</b>			
39. NAME OF CEMETERY or CREMATORY <b>Mount Auburn Cemetery</b>				40. LOCATION (City, town, or county) (State) <b>Baltimore, Md Maryland</b>			
41. DATE RECEIVED BY HEALTH DEPT. <b>AUG 7 1968</b>				42. NAME OF REGISTRAR <b>Robert E. Farley</b>			
43. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>				44. ADDRESS <b>1701 Laurens St.</b>			



A-450

68- 8073 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 8073

BIRTH NO. 68-07208

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>PAMELA ALLEN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>August 6, 1968</b> Hour <b>1:30 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3023 Gwynns Falls Pkwy</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 6, 1968 7:40 A.M.</b>	
6. SEX <b>female</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2001</b>	
9. DATE OF BIRTH <b>4-19-1968</b>		10. AGE (In years last birthday) <b>3 18</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWARD M. COOPER</b>		14. MOTHER'S MAIDEN NAME <b>SHIRLEY ELIZABETH ALLEN</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. <b>-0-</b>	
19. <b>484 X</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Interstitial Pneumonitis (DSII)</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>3</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m. <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22E. INJURY OCCURRED	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>8/6/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-8-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mount Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkner</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens St.</b>	

Wm. J. ...

K-6231

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8074 CERTIFICATE OF DEATH

REG. NO. 68- 8074

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH EDWARD KRASTEL

2. DATE AND HOUR OF DEATH

AUGUST 5, 1968

1.00 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

The Union Memorial Hospital

44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

Baltimore

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

4504 Ridge Road, Baltimore

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

08-29-87

9. AGE (In years  
last birthday)

80

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Farmer

10B. KIND OF BUSINESS OR INDUSTRY

Selfemployed

11. BIRTHPLACE (State or foreign country)

Unknown

12. CITIZEN OF WHAT COUNTRY?

America

13. FATHER'S NAME

Edward Krastel

14. MOTHER'S MAIDEN NAME

Florence Hausknecht

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

217-26-9203

17. INFORMANT

The Chart

ADDRESS

18.

491X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

Respiratory Insufficiency

(B) DUE TO, OR AS A CONSEQUENCE OF:

Chronic Bronchitis

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHabout  
2 yearsOTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Arteriosclerotic cardiovascular disease

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐  
WorkNot While ☐  
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 25, 1968 to August 5, 1968,  
that (I) (we) last saw the deceased alive on August 5, 1968 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Chun Kee Ryw

M.D.  
DEGREEAttending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

August 5, 1968

23C. PHYSICIAN'S  
NAME (Type)

CHUN KEE RYU

M.D.  
DEGREE

23D. ADDRESS

The Union Memorial Hospital

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8-8-1968

24C. NAME of CEMETERY or CREMATORY

St. Joseph's Cemetery

24D. LOCATION

Baltimore Co.

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 7 1968

25B. NAME OF REGISTRAR

Robert E. Talbott

25C. FUNERAL DIRECTOR

Lassahn Funeral Home 7401 Belair Road

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

The Union Memorial Hospital

male white

X

08-29-24 80

Florence Hunsicker

Unknown

American

the Court

Respected Jurors

Chambers

Winterschmidt cardiovascular disease

Chun Kee Kim M.D.

Chun Kee Kim M.D.

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August 2 July 22 23

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The Union Memorial Hospital

August 2 1923

R-100

68- 8075 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8075

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ROGER RUBY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month <u>August</u> Day <u>27</u> Year <u>1968</u> Estimated <input checked="" type="checkbox"/> <u>July</u> <u>27</u> , 1968		Hour <b>UNK</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2447 Maryland Avenue 9-27-68</b>		3. DATE PRONOUNCED DEAD Month <u>August</u> Day <u>3</u> Year <u>1968</u>		Hour <b>11:13 A.M.</b>
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>12-06</u>				
6. SEX <b>male</b>	7. RACE <b>white</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>Aug 23, 1898</b>		10. AGE (In years lost birthday) <b>xx 69</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?		E. STREET AND NUMBER <b>2447 Maryland Avenue</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Furniture Finishing</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		15. MOTHER'S MAIDEN NAME <b>?</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>xxx</b>		17. SOCIAL SECURITY NO. <b>220-09-9764A</b>		18. INFORMANT <b>Dorothy E. Seyfer Owings Mills, Md.</b>
19. <b>412.4</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:  20. DATE OF OPERATION <b>8/22/68</b> 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>422.1</b>				
21. AUTOPSY? (Yes or No) <b>Yes</b>				
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <u>Werner U. Spitz</u> M.D. EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> DATE SIGNED <b>8/4/68</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/6/68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbanks</b>		25C. FUNERAL DIRECTOR <b>Paul E. Charney</b>

Letter from M. E.'s office 9-27-68 M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-600		68-8076		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-8076	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>ROSE FARROW</b> <i>Rose Farrow</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH <i>8/4/68</i> <i>8:30 A.</i> M.			
FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i> <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND 21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> <i>53-00</i>			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>12-A FENWAY SOUTH 21221</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-29-87</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Secretary</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>LEE James Lee</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-32-8636-D</b>		17. INFORMANT ADDRESS <b>BCH: 4940 EASTERN AVENUE, BALTO., MD. 21224</b>			
18. <i>599.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <i>Sepsis</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Urinary tract infection</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>609X II</i>							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <i>7-27</i> 19 <i>68</i> to <i>8-4</i> 19 <i>68</i> , that (I) ( <u>we</u> ) last saw the deceased alive on <i>8-4</i> 19 <i>68</i> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ( <u>did</u> ) (did not) view the body after death.							
23A. SIGNATURE <i>Paul M. Kalkut</i>				23B. DATE SIGNED <b>8-4-68</b>		23C. PHYSICIAN'S NAME (Type) <b>PAUL KALKUT M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>8-8-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore City Md.</b>				25A. DATE REC'D BY HEALTH DEPT. <b>AUG 7 1968</b>			
25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>				25C. FUNERAL DIRECTOR <b>Lassahn Funeral Home 7401 Belair Road</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-655

68- 8077 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68- 8077

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Fred Herman</b>		2. DATE AND HOUR OF DEATH <b>8-5-68 2:00 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Carroll Co.</b>		56-00	
FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Maryland Gen. Hospital 827 Linden Ave. Baltimore, Md. 21201</b>		C. CITY OR TOWN <b>Finksburg</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>Rd. 1 Box 52</b>		9. AGE (In years last birthday) <b>5-24-98 70</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
S. SEX <b>M.</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>5-24-98 70</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired from Balmar Company</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>Thomas Herman</b>		14. MOTHER'S MAIDEN NAME <b>Mary Abrogast</b>		17. INFORMANT <b>Pre Adm. Typed 7/29/68</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>173-07-0047</b>		ADDRESS	
18. <b>205.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>ACUTE GRANULOCYTIC LEUCEMIA</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
204.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2/1</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>YES</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7-29</b> 19 <b>68</b> to <b>8-5</b> 19 <b>68</b> , that (I) <u>(we)</u> lost saw the deceased olive on <b>8-5</b> 19 <b>68</b> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <b>Delfa C. Gomez, D.O.</b>				23B. DATE SIGNED <b>8-5-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Delfa C. Gomez, D.O.</b>				23D. ADDRESS <b>Reisterstown, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/8/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Evergreen Memorial Gardens</b>	
24D. LOCATION <b>Finksburg, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 7 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fink</b>	
25C. FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons</b>		25D. ADDRESS <b>Reisterstown, Md.</b>			

PA-6013

Frankford

PA 1 Box 35

PA-44-18

Temporarily

for your files

Mr. [illegible]  
[illegible]  
[illegible]

X

W

M

James H. [illegible]

PA-44-18

PA-44-18

PA-44-18

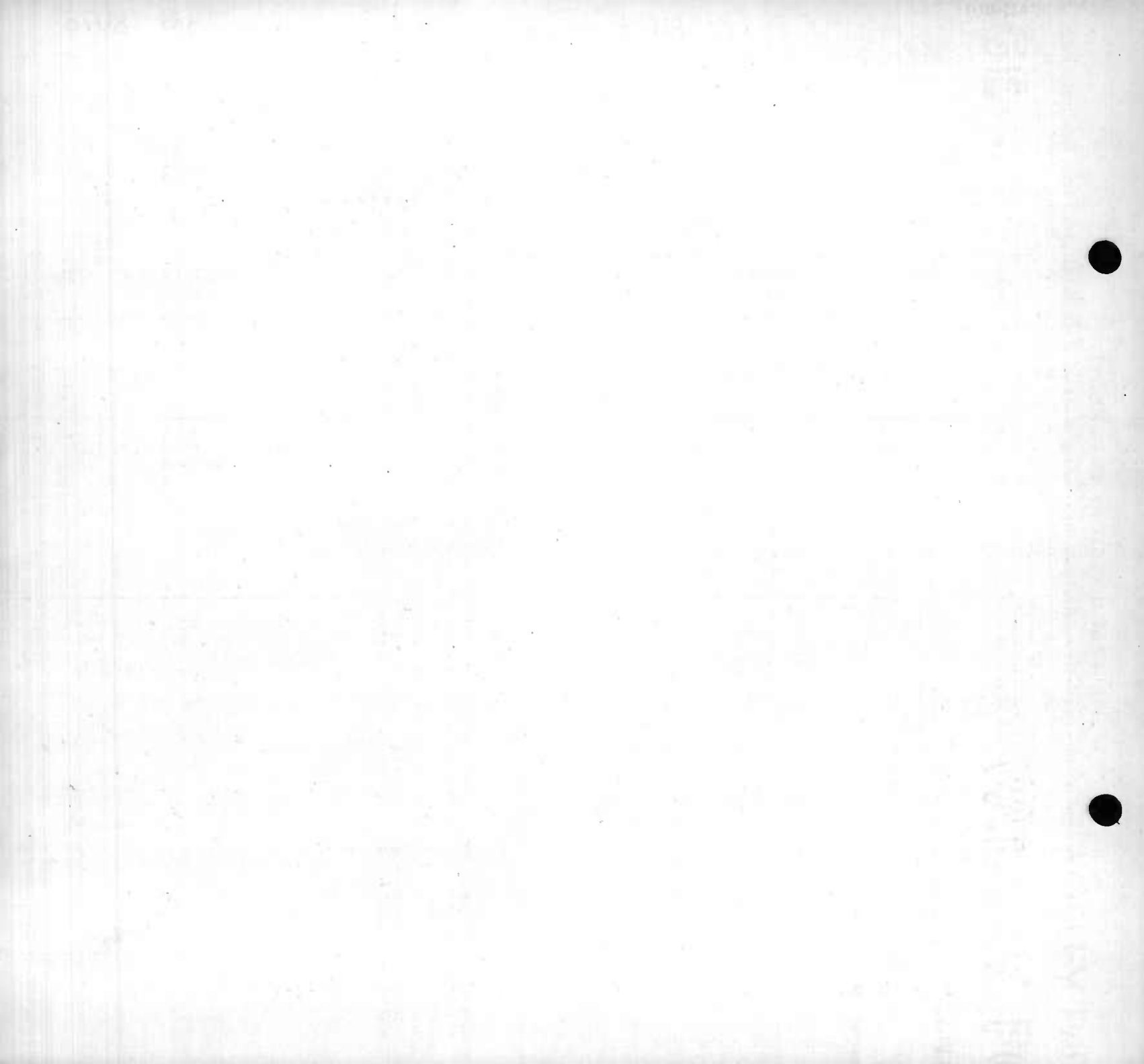
X

PA-44-18

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

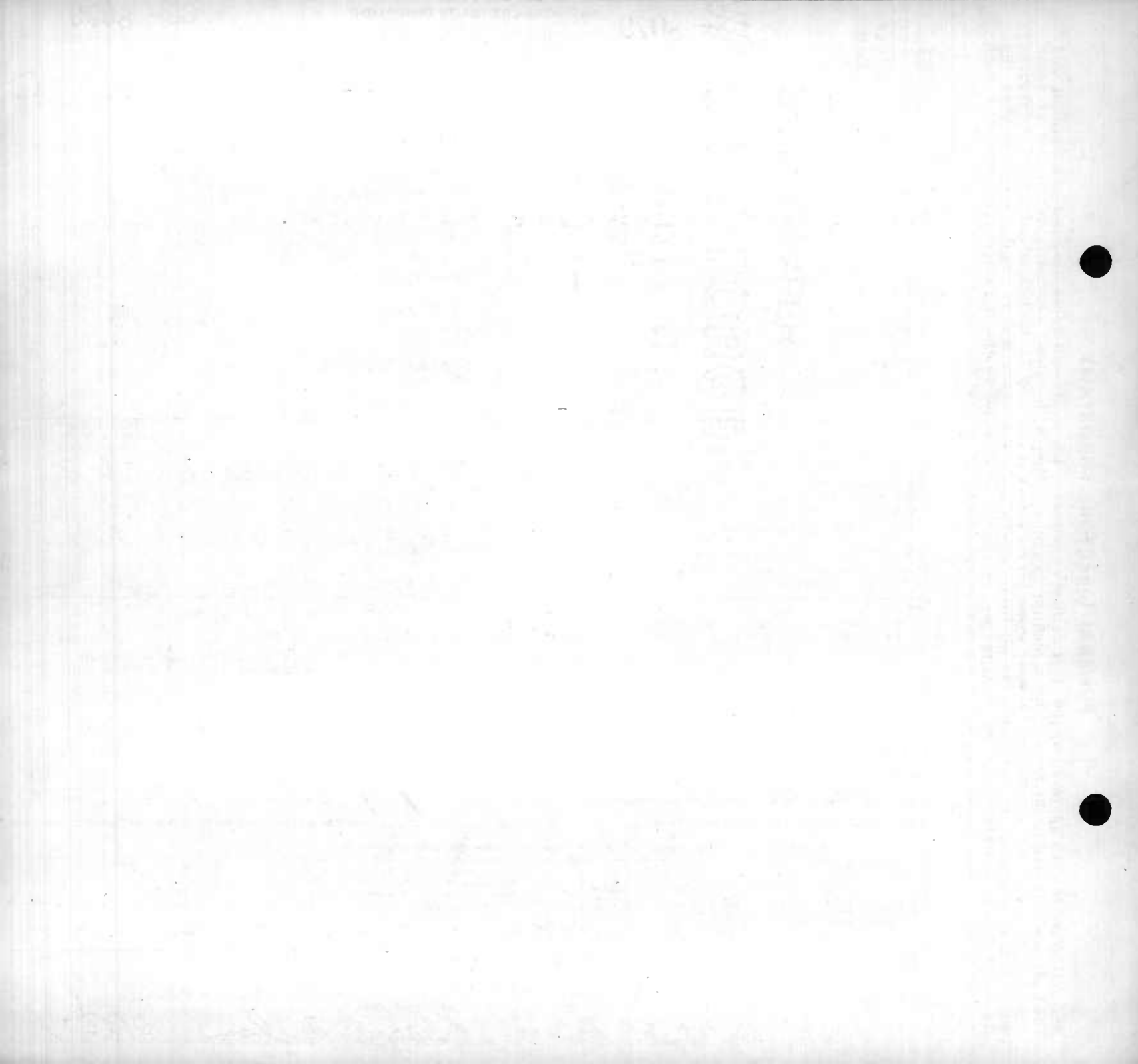
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8078	
BIRTH NO. 68-14793		68- 8078		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Baby Girl Miles.			2. DATE AND HOUR OF DEATH 8-1-68 12 <sup>07</sup> A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 947 N. WOLFE ST.		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-31-68	9. AGE (In years last birthday) 60	10. Under 1 Yr. Months: Days: 5 52
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME LAVELLA MILES		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 486X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 763.5- II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). None			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Extremoprematurity - 28 weeks. & neonatal pneumonia. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 hours.
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/31/68 19 to 8/1/68 19, that (I) (we) last saw the deceased alive on 12 <sup>07</sup> AM 8/1 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE JESS G. THOENE, M.D. JESS G. THOENE				23B. DATE SIGNED 8/1/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 550 North Broadway, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 8/2/68		24C. NAME OF CEMETERY or CREMATORY The Johns Hopkins Hosp	
24D. LOCATION (City, town, or county) (State) Balto., Md		25A. DATE REC'D BY HEALTH DEPT. AUG 8 1968			
25B. NAME OF REGISTRAR Robert E. Farley, Jr.		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL			



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				68- 8079		REG. NO. 68- 8079	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Gertrude Gibson				8-6-68 5 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Bolton Hill Nursing & Convalescent Center				A. STATE B. COUNTY Maryland Baltimore			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 3031 Spaulding Ave.							
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
Female	Negro	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	1886	88	Housewife		
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
West Virginia				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown Jack Johnson				Hester Raymond			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				214-58-9127		Elizabeth Hill 5334 Bayview	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osseous, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Cerebral Vascular accident 3 days			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Anteriorly Ruptured Aorta 7 yrs			
				(C) Anteriorly Ruptured Aorta 7 yrs			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				Pneumonia, cerebral hemorrhage, right 2-3 years			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
						20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/6 1968 to 8/6 1968, that (I) (we) last saw the deceased alive on 8/6 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
ALLAN H. MACHT M.D. 2 E. READ ST.				8/6/68			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial 8-8-68				8-8-68		Baltimore	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 8 1968				E. J. E. Johnson		E. J. E. Johnson 3100	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

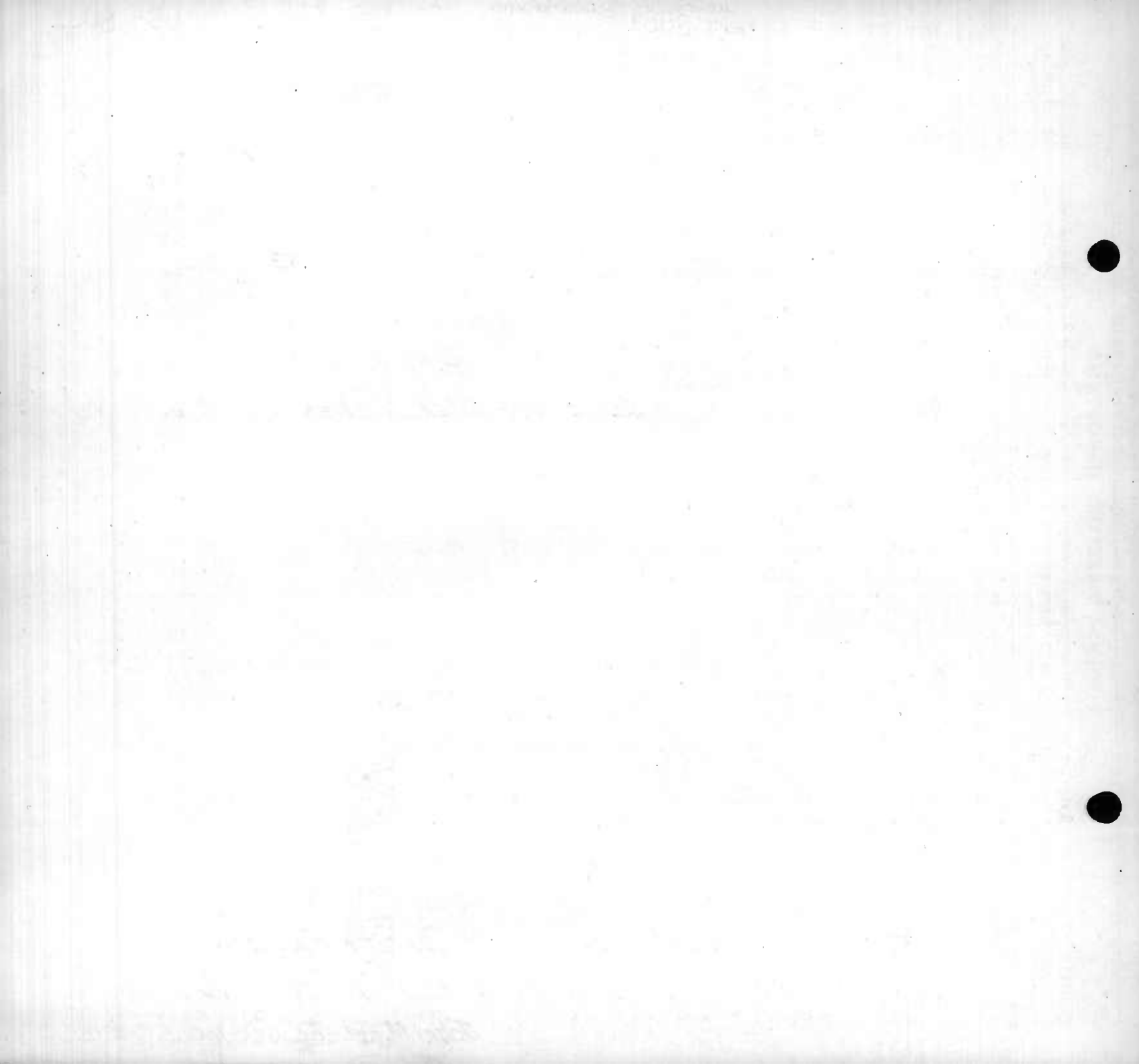
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
B-652 68-8080		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Baranowski, William John		8-6-68 640 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
North Charles General Hospital			Maryland 21213		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			3451 Mayfield Avenue		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
M	W		Jan. 9, 1910	58	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Milk Salesman		Hoontz Dairy		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Baranowski, John D.			Harchut, Sophia		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SECURITY NO.	17. INFORMANT		ADDRESS
NO		212-10-8676	N. C. Gen. Hosp. chart		
18. 433.7 CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Arrest					
(B) Cerebrovascular Thrombosis DUE TO, OR AS A CONSEQUENCE OF:					
(C)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
332X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from August 4 1968 to August 6 1968, that (I) (we) last saw the deceased alive on August 6 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		DEGREE		23B. DATE SIGNED	
Theodore Niznik				8-6-68 7 a.m.	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Niznik, Theodore, M.D. (Attending)		429 S. Chester Street 21231			
24A. BURIAL CREMATION, REMOVAL (Specify)		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		HOLY ROSARY CEM.		DUNDALK MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 8 1968		Robert E. Taylor, M.D.		John M. WEBERT-SORRIS INC 401 S. CHESTER	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">68- 8081</span>
<div style="display: flex; justify-content: space-between;"> <span>P. 362 68- 8081</span> <span style="font-size: 1.5em;">CERTIFICATE OF DEATH</span> </div>				
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Michael W. Peterson</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>8/6/68</u> <u>5:15 A.M.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u> <u>38</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>7322 Waldman Avenue</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/10/14</u>	9. AGE (In years lost birthday) <u>53</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sup. Printing</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>FRANK Peterson</u>		
14. MOTHER'S MAIDEN NAME <u>ZAMENSKA</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>212-10-1193</u>		17. INFORMANT <u>HELEN WEBER</u> ADDRESS <u>7322 WALDMAN AVE</u>		
18. <u>193X I</u> CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>EXSANGUINATION</u> DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>EROSION of Great vessels</u> DUE TO, OR AS A CONSEQUENCE OF:		
		(C) <u>Carcinoma thyroid</u>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>2 months</u> <u>15 months</u>				
19. <u>194X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>6/67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cc Thyroid</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>8/5/68</u> 19 <u>68</u> to <u>8/6</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8/6</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>FLOYD B. MARDEL MD</u>		23B. DATE SIGNED <u>8/6/68</u>		23C. PHYSICIAN'S NAME (Type) <u>FLOYD B. MARDEL M.D.</u>
23D. ADDRESS <u>UNIVERSITY HOSPITAL</u>		24A. BURIAL CREMATION, REMOVAL (Specify)		
24B. DATE <u>8-9-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>GARDEN OF FAITH CEM.</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO MARYLAND</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 8 1968</u>		25B. NAME OF REGISTRAR <u>John M. Weber</u>		25C. FUNERAL DIRECTOR ADDRESS <u>John M. Weber &amp; Sons Inc. S. CHESTER ST.</u>



**FUNERAL DIRECTOR: IMPORTANT**

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68- 8082

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

REG. NO. 68- 8082

BIRTH NO. <span style="float: right;">7</span>		1. NAME OF DECEASED (Type or Print) <u>Charlie Hampton</u>		2. DATE AND HOUR OF DEATH <u>August 6, 1968</u> <u>4:55</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sina Hospital</u> <u>42</u>			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <u>3900 BOARMAN AVE</u>		
5. SEX <u>Male</u>	6. RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1-1896</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Iron Foundry</u>			11. BIRTHPLACE (State or foreign country) <u>Cartersville Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Louis Morton</u>			14. MOTHER'S MAIDEN NAME <u>Dilsey</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>229-20-0718A</u>	17. INFORMANT <u>Missie Hampton</u> ADDRESS <u>3900 Boarmans Bm</u>		
18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF:		
			(C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>old CVA</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>old CVA</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>Aug. 6</u> 19 <u>68</u> to <u>Aug 6</u> 19 <u>68</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>Aug 6</u> 19 <u>68</u> and that in ( <del>my</del> ) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did</del> ) ( <del>not</del> ) view the body after death.					
23A. SIGNATURE <u>Martin Horowitz</u>			23B. DATE SIGNED <u>8/6/68</u>		23C. PHYSICIAN'S NAME (Type) <u>Robert E. Seligman</u>
23D. ADDRESS <u>138 N. Gettysburg St</u>			23E. FUNERAL DIRECTOR <u>Wm. H. Seligman</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Common</u>		24B. DATE <u>8/8/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Howe Baptist Church</u>	
24D. LOCATION (City, town, or county) (State) <u>Cartersville Va</u>		24E. DATE REC'D BY HEALTH DEPT. <u>AUG 8 1968</u>		24F. NAME OF REGISTRAR <u>Robert E. Seligman</u>	

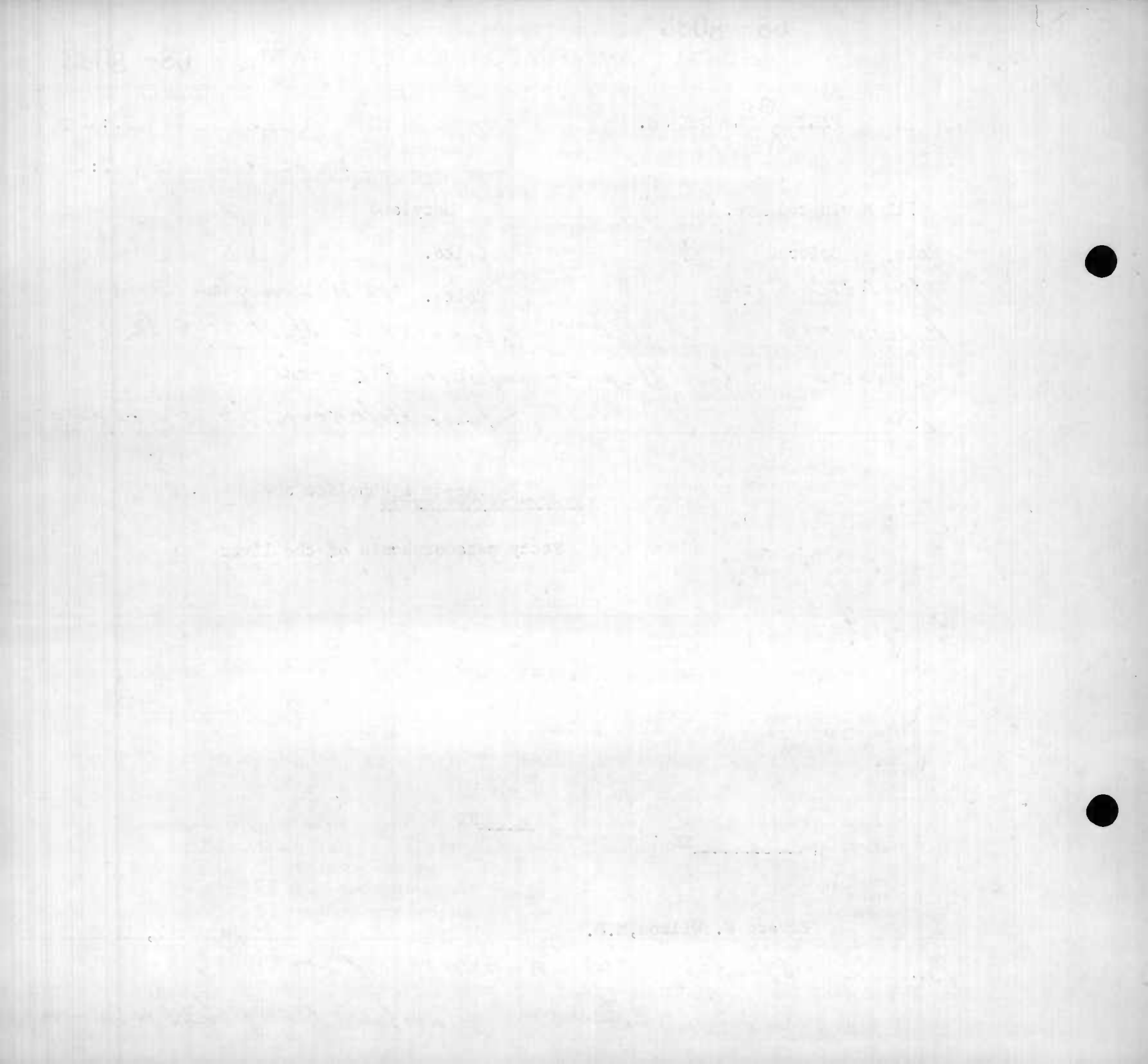


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8083

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WALTER HOLBROOK JR.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 8 6 68 5:15 p. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>712 Newington Ave.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 6 1968 5:15 p.m.</b>	
6. SEX <b>Male</b>		7. RACE <b>Colored</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto.</b>	
9. DATE OF BIRTH <b>4/21/1922</b>		10. AGE (In years last birthday) <b>? 46</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTO MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Gen Hospital</b>	
15. MOTHER'S MAIDEN NAME <b>Julia O'Brien</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>571.0</b>		18. INFORMANT <b>Julia Holbrook 2708 W. Fairmount</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute alcoholism and Fatty metamorphosis of the liver</b>		20. CAUSE OF DEATH (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>		22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Edward F. Wilson</b>		DATE SIGNED <b>August 7, 1968</b>	
EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>8/10/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT RUSSELL</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 8 1968</b>	
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Manhattan D. Hughes</b>	
ADDRESS <b>138 W. Gilman St</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

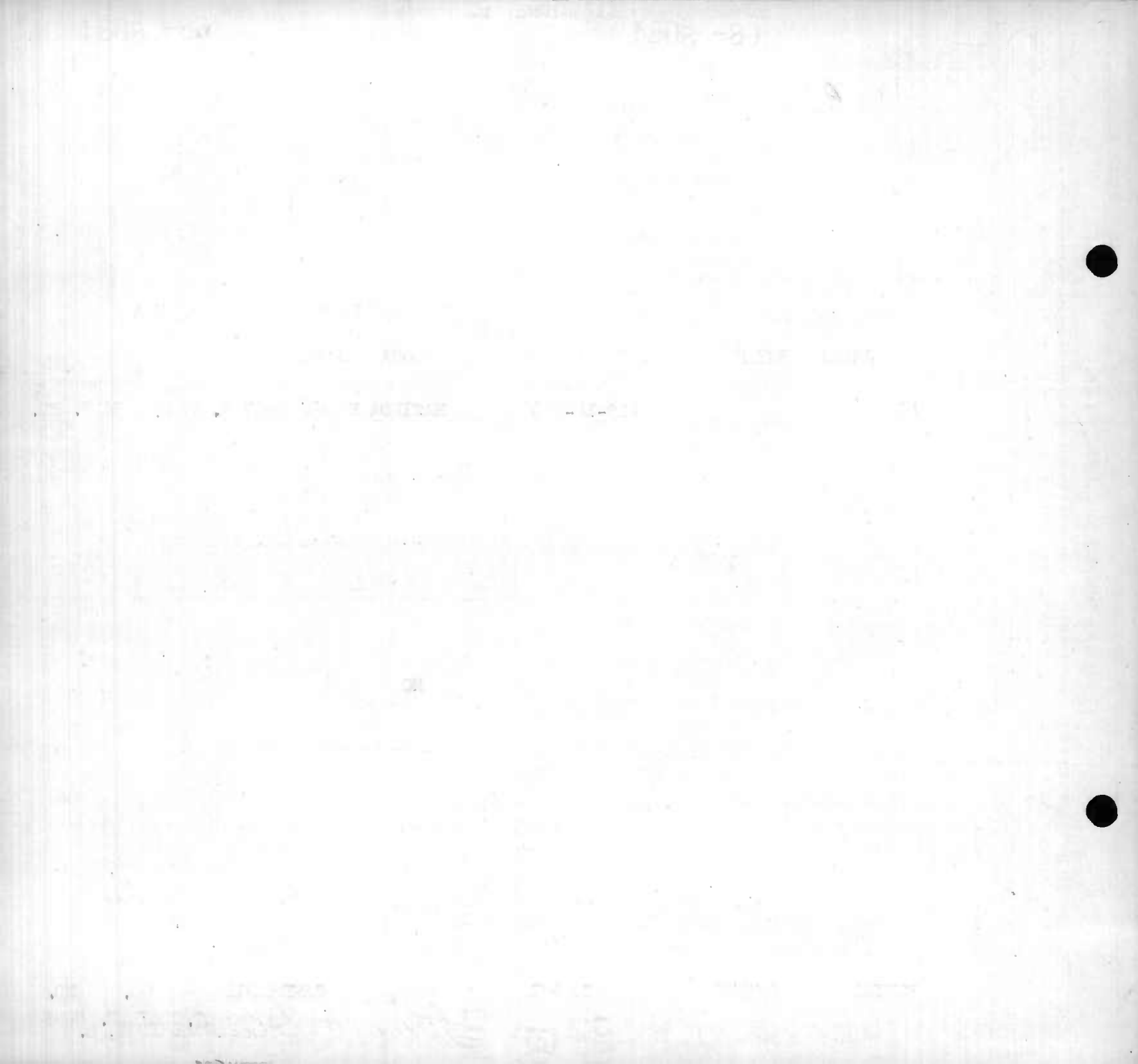
BALTIMORE CITY HEALTH DEPARTMENT

68- 8084

CERTIFICATE OF DEATH

REG. NO. 68- 8084

BIRTH NO.		1. NAME OF DECEASED (Type in full) <b>Irene Connish</b>		2. DATE AND HOUR OF DEATH <b>7/30/68</b>   <b>10:40 P</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University Hospital</b>				C. CITY OR TOWN <b>Baltimore</b> INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>2647 S Paca St #30</b>	
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/1/85</b>	9. AGE (In years last birthday) <b>83</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>JAMES BRYAN</b>			14. MOTHER'S MAIDEN NAME <b>DORA BRYAN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-14-2648</b>		17. INFORMANT <b>MATILDA KEENE</b> ADDRESS <b>2647 S. PACA BALT. MD.</b>	
18. <b>43791</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>331X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>13 Days</b>	
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7/20/68</b> to <b>7/30/68</b> and that (I) (we) last saw the deceased alive on <b>7/30/68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Martin S Schwartz MD</b>				23B. DATE SIGNED <b>7/30/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Martin S Schwartz MD</b>				23D. ADDRESS <b>University Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/5/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>BETHEL</b>	
24D. LOCATION (City, town, or county) <b>CAMBRIDGE</b>		24E. DOR. <b>DOR.</b>		24F. MD. <b>MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fellers</b>		25C. FUNERAL DIRECTOR <b>ST. CLAIR F. HOME</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8085 BALTIMORE CITY HEALTH DEPARTMENT

REG NO.

68- 8085

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Lillian A Warren

2. DATE AND HOUR OF DEATH

August 5, 1968

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

90

Hood Nursing Home  
5313 Edmondson Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

Baltimore

53-00

C. CITY OR TOWN

Arbutus

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

5106 Leeds Avenue

5. SEX

Female

6. RACE

White

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

8-21-1894

9. AGE (In years last birthday) 73

74

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Mack

14. MOTHER'S MAIDEN NAME

Theresa Kuger

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Mr. William E. Warren, 5106 Leeds Avenue

ADDRESS

21227

18.

412.21

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 8 1952 to Aug 5 1968, that (I) (~~we~~) last saw the deceased alive on July 29 1968 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

8/5/68

23C. PHYSICIAN'S NAME (Type)

Dr. John C. Healy

23D. ADDRESS

1311 Francis Avenue, Balto., Md. 21227

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-7-68

24C. NAME OF CEMETERY or CREMATORY

Loudon Park Cemetery

24D. LOCATION

(City, town, or county)

(State)

Frederick Ave., Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 8 1968

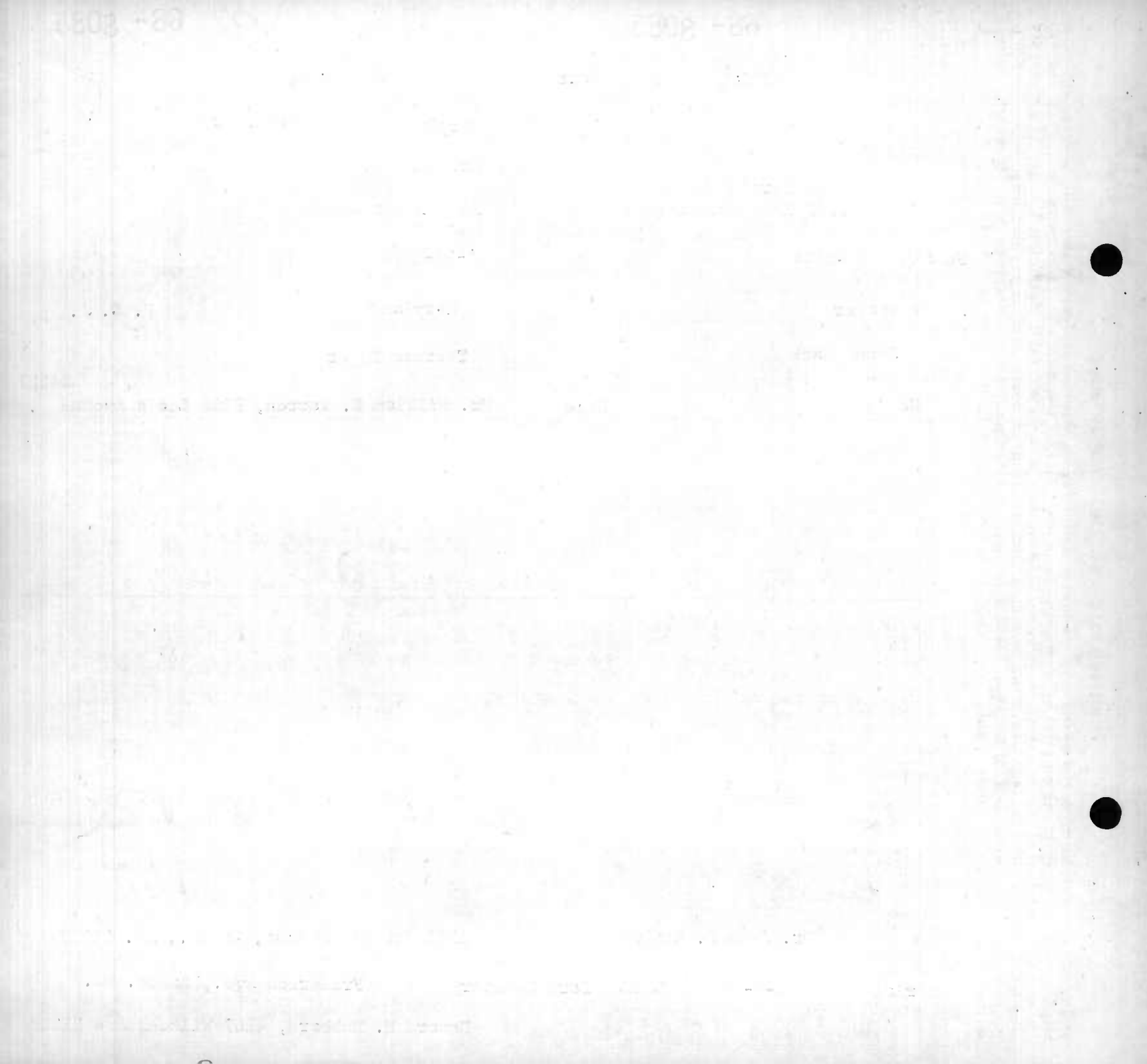
25B. NAME OF REGISTRAR

Robert E. Farber

25C. FUNERAL DIRECTOR

Howard H. Hubbard, 4107 Wilkens Ave 21229

ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 8086 4
BIRTH NO. <b>68-14739</b>		<b>68- 8086</b>		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>Monica Angela Kronen</b> <b>BABY GIRL KRONEN</b>			2. DATE AND HOUR OF DEATH <b>AUGUST 5 1968</b>   <b>1:30 P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>34 BON SECOURS HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> <b>53-00</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>34 BON SECOURS HOSPITAL</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>555 TA ROGERS FORGE RD.</b>		
5. SEX <b>F</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 5 1968</b>	9. AGE (In years last birthday) <b>8</b>	If Under 1 Yr. Months Days <b>10</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NEW BORN</b>		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		13. FATHER'S NAME <b>RICHARD KRONEN</b>			
14. MOTHER'S MAIDEN NAME <b>LORRAINE MORGAN MIRABILE</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. -----		17. INFORMANT <b>Richard Kronen</b> Same As Above			
18. <b>776.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Stenocardia</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Ischemia</b> (C) -----		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>762.5 II</b>			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). -----		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -----		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -----		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -----		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -----			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -----		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -----	
22. I certify that (I) (this hospital) attended the deceased from <b>August 5 1968</b> to <b>August 5 1968</b> , that (I) (we) last saw the deceased alive on <b>August 5 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Estrellita P. Trias M.D.</b> OEGRE				23B. DATE SIGNED <b>August 5, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>ESTRELLITA P. TRIAS M.D.</b> OEGRE				23D. ADDRESS <b>BON SECOURS HOSPITAL BALTO. MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-7-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cem.</b>	
24D. LOCATION <b>Balto., Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>AUG 8 1968</b>			
24F. NAME OF REGISTRAR <b>Robert E. Taylor</b>		24G. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, INC. Towson, Md.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-8087</u>
BIRTH NO. <u>68-8087</u>		1. NAME OF DECEASED (Type or Print) <u>FERNANDEZ, Genevieve</u>		
2. DATE AND HOUR OF DEATH <u>8-6-68</u> <u>7 25 A. M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>E</u>		5. FULL NAME OF HOSPITAL OR INSTITUTION <u>48 MARYLAND GENERAL Hosp.</u>		
6. DATE OF BIRTH <u>10-10-9900</u>		7. AGE (In years last birthday) <u>69</u>		
8. CITY OR TOWN <u>BALTIMORE</u>		9. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
10. STREET AND NUMBER <u>1301 ST. PAUL ST.</u>		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Louis Henry</u>		
14. MOTHER'S MAIDEN NAME <u>Clara Walter</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>216-07-0406</u>		17. INFORMANT <u>Hosp. Record</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>410.91</u>		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ARTERIOSCLEROTIC C-V. DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ATRIAL FIBRILLATION, ARTERIAL EMBOLIZATION</u>		
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>420.1 II</u>		21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>5 yr.</u>		
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>420.1 II</u>		23. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <u>7/21/68</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Femoral Embolectomy, Sympathectomy</u> 20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <u>7/21/68</u> 19 to <u>8/6/68</u> 19 that (I) (we) last saw the deceased alive on <u>8/5/68</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <u>C. Thomas Flotte M.D.</u>		23B. DATE SIGNED <u>8/6/68</u>		
23C. PHYSICIAN'S NAME (Type) <u>C. THOMAS FLOTTE, M.D.</u>		23D. ADDRESS <u>827 Linden Ave., Baltimore, Md 21201</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>AUG 8 1968</u>		
24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 8 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Faltys</u>		
25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks, Inc.</u>		25D. ADDRESS <u>1217 St. Paul St. Balto., Md. 21202</u>		

SE

James Henry  
Barnes

100  
Barnes

100

100

100

52-30-78

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-8088	
1. NAME OF DECEASED (Type or Print) <b>Helen E. Pfeil</b>		HELEN PFEIL		2. DATE AND HOUR OF DEATH <b>8/2/68</b> <b>7:30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>26-09</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND 21224</b>		E. STREET AND NUMBER <b>3516 ELLIOTT STREET 21224 007</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-4-93</b>	9. AGE (In years lost birthday) <b>75</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOUSE WORK</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND, BALTIMORE</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>ERVIN WHEELER (DEC.)</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH (DEC.) BURNHARDT</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT ADDRESS <b>RECORDS: BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVE., BALTO., MD. 21224</b>	
18. <b>4811</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Cardiovascular Collapse</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypoxemia</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Lobar pneumonia</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A). <b>490X II</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>8/1</b> 19 <b>68</b> to <b>8/2</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Kenneth E. Fligsten M.D.</b>		23B. DATE SIGNED <b>8-2-68</b>		23C. PHYSICIAN'S NAME (Type) <b>KENNETH E. FLIGSTEN, M.D.</b>	
23D. ADDRESS <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVE., BALTO., MD. 21224</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-6-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>OAK LAWN CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>7225 EASTERN BLVD, BALTO., CO., MD.</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 8 1968</b>	
25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Charles J. Geiler</b>		25D. ADDRESS <b>901 S. CONKLING ST. BALTO., 21224, MD.</b>	

10/1/71

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-8089	
68-8089				CERTIFICATE OF DEATH	
BIRTH NO. 520		1. NAME OF DECEASED (Type or Print) <b>JONES, ELEANOR M.</b>		2. DATE AND HOUR OF DEATH <b>8/3/68 - 12<sup>30</sup> P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>26-05</b>		5. CITY OR TOWN <b>BALTIMORE</b> C. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205</b>		E. STREET AND NUMBER <b>450 ELRINO STREET # 21224</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-15-10</b>	9. AGE (In years last birthday) <b>57</b>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>GEORGE SPEDDEN</b>		14. MOTHER'S MAIDEN NAME <b>ANNA MAGAVIETSKI</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Thomas P. Jones 450 S. Elrino St. #21224</b>	
18. <b>174 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Insufficiency</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) <b>Metastatic Cancer Breast</b> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. <b>170 X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>June 16, 1968</b> to <b>Aug. 3, 1968</b> that (I) (we) last saw the deceased alive on <b>Aug 3, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Richard R. Didinato M.D.</b>		23B. DATE SIGNED <b>8/3/68</b>		23C. PHYSICIAN'S NAME (Type) <b>RICHARD R. DIDINATO M.D.</b>	
23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-7-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>7225 Eastern Blvd. Ba. Co., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 8 1968</b>	
25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>Charles S. Geiler</b>		25D. ADDRESS <b>6224 Eastern Ave, BALTO., 21224, MD.</b>	

Plenary Assembly  
Missouri State Fair

Aug 2 June 18

Richard P. B. B. B. B.

8/18/62

K-400

68- 8090 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8090

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Scott Gerald/Kelly</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> 8 3 1968 Hour 8:40 AM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>43 South Baltimore General Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 3 1968 8:50 AM	
6. SEX <b>M</b>		7. RACE <b>W</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
9. DATE OF BIRTH <b>Jan. 20, 1915</b>		10. AGE (In years last birthday) <b>53</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. R. R.</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Louise Kelly - 37 Talbott St., Baltimore 21225</b>		ADDRESS	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arterio-sclerotic cardio vascular disease.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. <b>422.1</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		DATE SIGNED <b>Aug. 3, 1968</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 6, '68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Ritchie Hgwy., B. A. Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>	
25C. FUNERAL DIRECTOR <b>George J. Gonce, 4001 Ritchie Hgwy., Baltimore</b>		ADDRESS	

W/ALFRED W. J. G. H. G.

ALFRED W. J. G. H. G.

23.1.2011

FUNERAL DIRECTOR: IMPORTANT

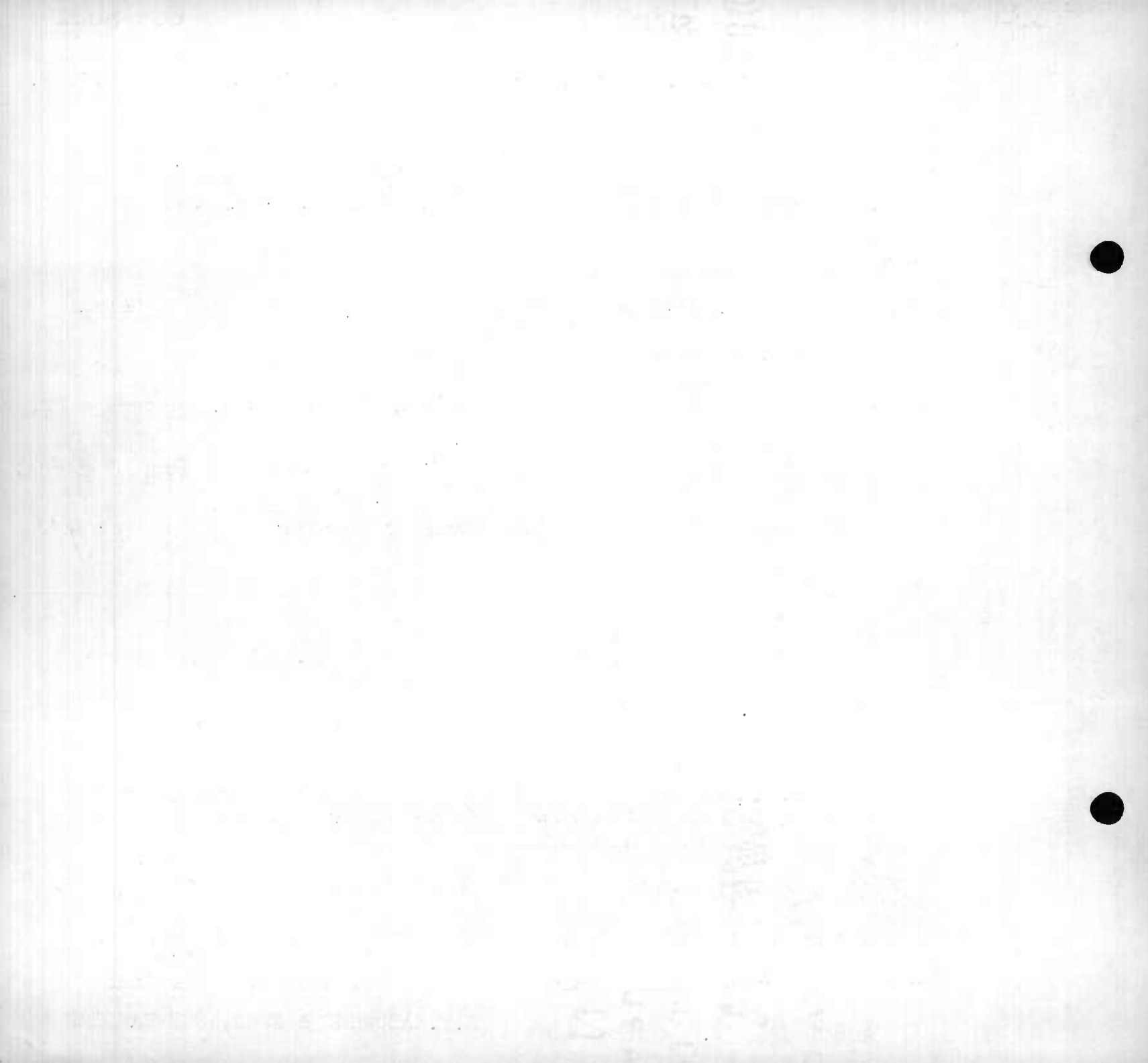
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

## 68- 8091 CERTIFICATE OF DEATH

REG. NO. 68- 8091

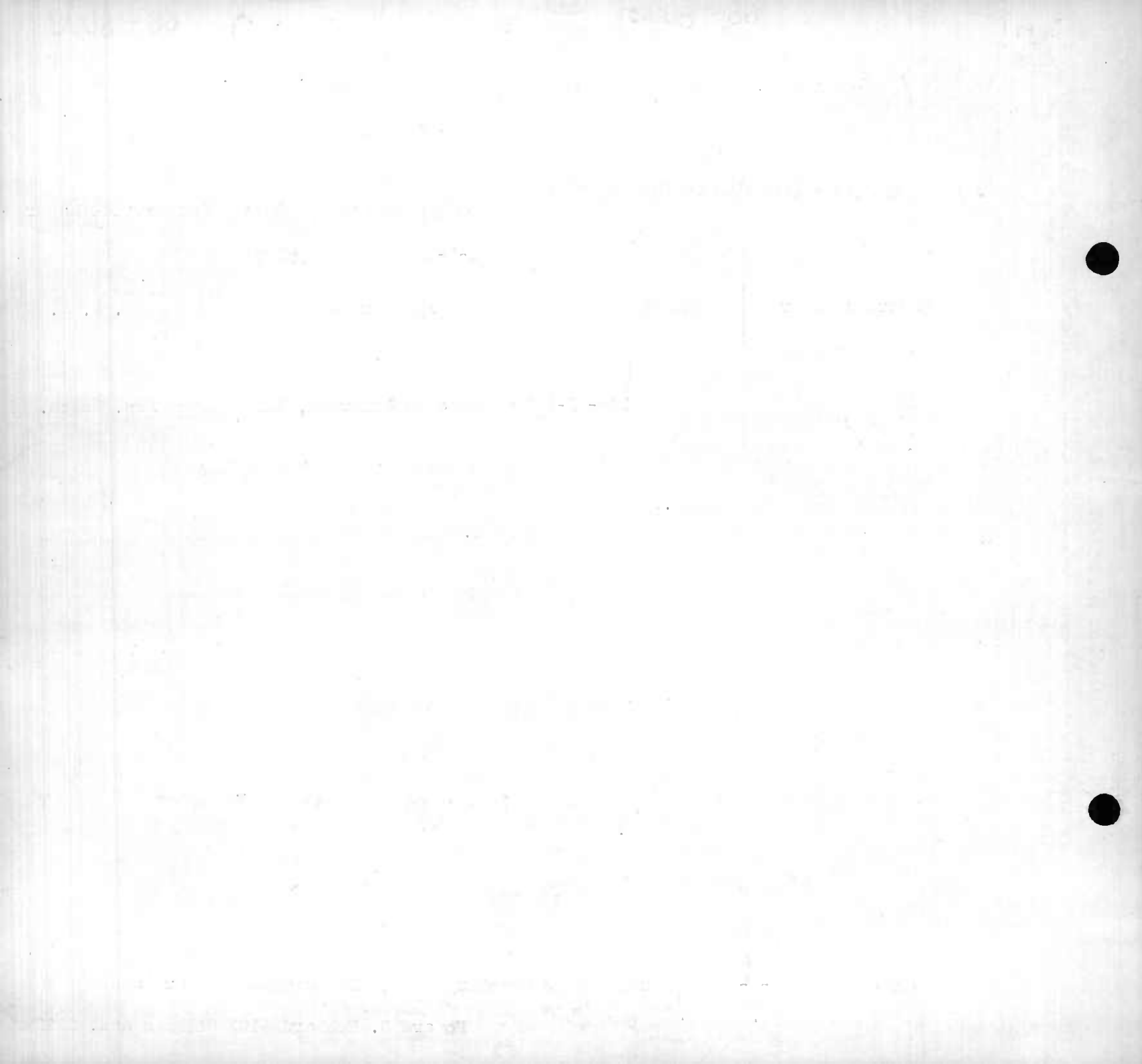
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>SISTER M. FABIANA [Jozefa Soszynska]</b>		2. DATE AND HOUR OF DEATH <b>August 5, 1968 9:00 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1-05</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>100 S. Patterson Park Avenue</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nun</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Religious Order</b>		8. DATE OF BIRTH <b>11/23/1893</b>	
13. FATHER'S NAME <b>Ignacy Soszynski</b>		14. MOTHER'S MAIDEN NAME <b>Ewa Gierek</b>		9. AGE (In years last birthday) <b>74</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>	
17. INFORMANT <b>Sister M. Angela, 100 S. Patterson Pk. Av</b>		ADDRESS <b>100 S. Patterson Park Avenue</b>		12. CITIZEN OF WHAT COUNTRY? <b>Poland</b>	
18. <b>174X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Generalized Carcinomatosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>20yrs</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <b>Carcinoma of breast</b> (B) DUE TO, OR AS A CONSEQUENCE OF <b>4 1/2 mos</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
170X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>170X II</b>		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 1948</b> to <b>present</b> 19 <b>68</b> that (I) (we) last saw the deceased alive on <b>27 July</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Arthur G. Siwinski</b>		23B. DATE SIGNED <b>7 Aug 1968</b>		23C. PHYSICIAN'S NAME (Type) <b>Arthur G. Siwinski M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/9/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Rosary</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>M.F. SADOWSKI &amp; SONS, 1808 EASTERN AVE</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. ADDRESS <b>1808 Eastern Ave</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 8092
<div style="display: flex; justify-content: space-between;"> <span>68- 8092</span> <span><b>CERTIFICATE OF DEATH</b></span> <span>68- 8092</span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>SCHAFERMAN GEORGE</b>		2. DATE AND HOUR OF DEATH <b>8-6-68 6-10 PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL OF MARYLAND</b>			C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>1138 McADOO AVE Catonsville Manor</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-2-1898</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mattress Maker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bedding</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>Unknown</b>		
14. MOTHER'S MAIDEN NAME <b>Unknown</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>216-05-7478</b>			17. INFORMANT ADDRESS <b>Emma Schafferman, 1138 McAdoo Ave. Balto. 07</b>		
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIORESPIRATORY Failure</b></p> <p>(B) <b>obstructive EMPHYSEMA Chronic bronchitis</b></p> <p>(C) <b>Asxvd</b></p> </div> </div>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7-27-68</b> 1968 to <b>8-6-</b> 1968, that (I) (we) last saw the deceased alive on <b>8-6-68</b> 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J Baig</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>DR BARBU CALIN</b>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-9-68</b>		24C. NAME of CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Pikesville Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 8 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard 4107 Wilkens Ave. 21229</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
68- 8093					REG. NO. 68- 8093				
BIRTH NO.					DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <u>MARY ANNA LINTON</u>					5:45 68 1 P. M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					A. STATE B. COUNTY				
38 <u>UNIV OF MD. HOSP.</u>					<u>MD</u>				
					C. CITY OR TOWN		D. INSIDE CITY LIMITS?		
					<u>BALTIMORE</u>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER				
					<u>215 S. Gilmore ST BALT 20223</u>				
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>F</u>	<u>W</u>	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		<u>4/27/09</u>	<u>59</u>	<u>MARYLAND</u>		<u>USA</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY				
<u>Domestic</u>									
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
<u>John Webster</u>					<u>Lottie Benton</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
<u>No</u>					<u>---</u>		<u>SON 215 S. Gilmore</u>		
18. <u>157.9 I</u>					CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					?				
ANTECEDENT CAUSES					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>METASTATIC CARCINOMA Lungs</u>				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) <u>CARCINOMA STOMACH</u> <u>Months</u>				
					(C) <u>---</u>				
19. <u>157.9 II</u>									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
<u>0</u>					<u>NO</u>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?				
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (1) (this hospital) attended the deceased from <u>7/2</u> 19 <u>68</u> to <u>8/5</u> 19 <u>68</u> , that (1) (we) last saw the deceased alive on <u>8/5</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (do not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
<u>I. Frank Hartman M.D.</u>					<u>8/5/68</u>				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
<u>I. FRANK HARTMAN II M.D.</u>					<u>Univ of Md. Hosp</u>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
<u>BURIAL</u>		<u>8/8/1968</u>		<u>ST. JOHN'S Cam.</u>		<u>DEAL Island MD</u>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
<u>AUG 8 1968</u>		<u>Robert E. Fairbairn</u>		<u>Edw. J. Gower</u>		<u>4001 Ritchie Hwy</u>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

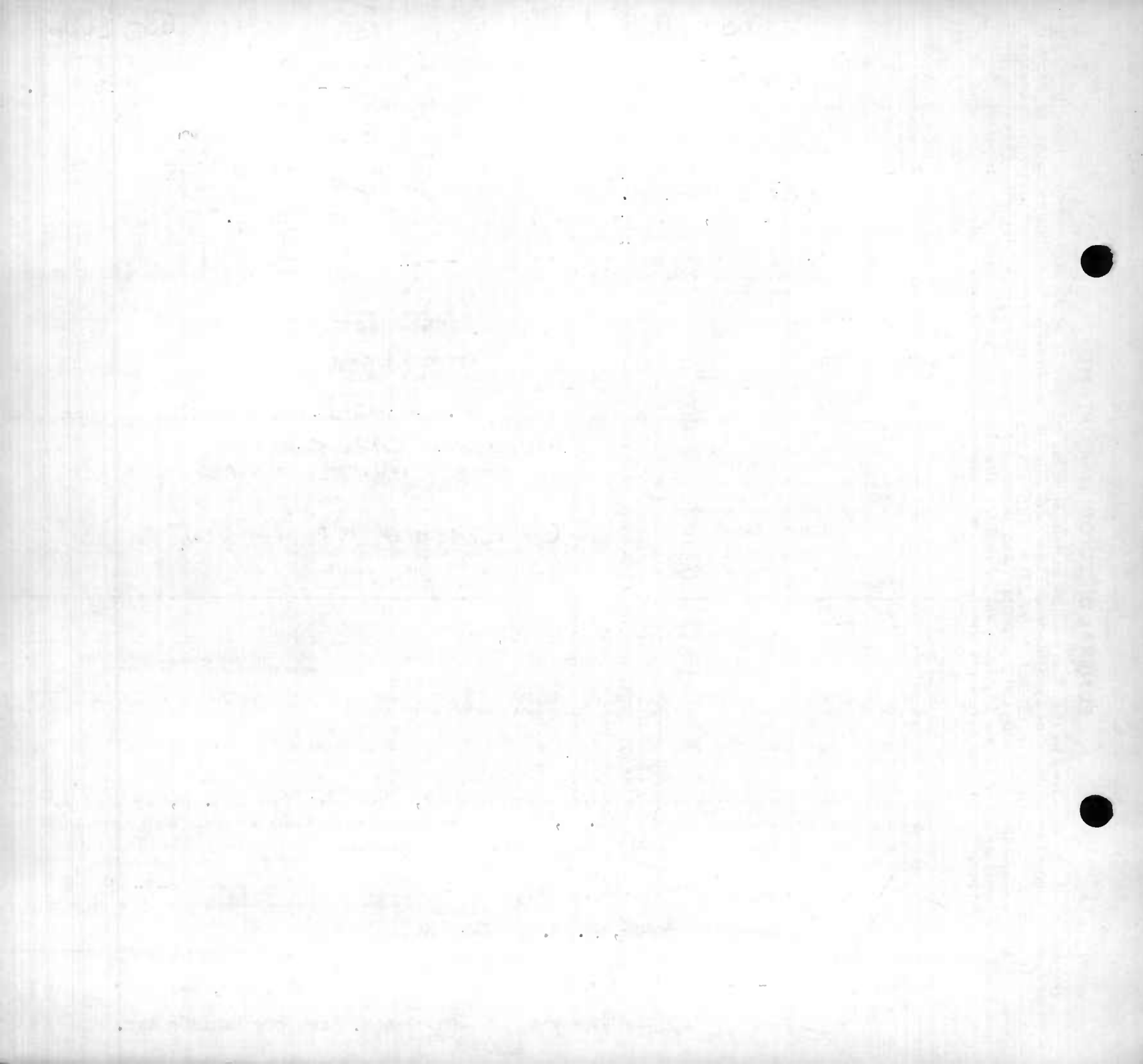
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-8094 4</u>
BIRTH NO. <u>68-14390</u>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <u>Parks, Baby <del>Robert</del></u>		2. DATE AND HOUR OF DEATH <u>8/5/68 4:05 am</u>		M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> <u>44</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER <u>2351 Annapolis Road</u> <u>21230</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/2/68</u>	9. AGE (In years last birthday) <u>3</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baby</u>		10B. KIND OF BUSINESS OR INDUSTRY —		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William Parks</u>		14. MOTHER'S MAIDEN NAME <u>Katzenberger</u> <u>Carol Ann</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Carol Ann Parks</u> ADDRESS <u>21230</u> <u>2351 Annapolis Rd.</u>
18. <u>743.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiorespiratory arrest</u> <u>2 hours</u>		
		(B) <u>Aspiration</u> <u>2 hours</u> DUE TO, OR AS A CONSEQUENCE OF:		
		(C) <u>Congenital CNS defect C/S</u> <u>3 days</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>18/3/68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Circumcision</u>		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>August 2</u> 19 <u>68</u> to <u>August 5</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>August 5</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Andrew S.O. Sun M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/5/68</u>
23C. PHYSICIAN'S NAME (Type) <u>ANDREW S.O. SUN MD.</u>		23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>8/7/68</u>	24C. NAME OF CEMETERY or CREMATORY <u>Meadowridge Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Dorsey Md. Howard Co., Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 8 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Finkbeiner</u>		25C. FUNERAL DIRECTOR <u>McElly F.A.</u> ADDRESS <u>237 Patapsco Ave. 21225</u>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">68- 8095</span>
68- 8095		<b>CERTIFICATE OF DEATH</b>		
BIRTH NO. <span style="font-size: 1.2em;">13-6210</span>		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Virginia Iola Brooks</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">8-6-68 10:10 p.m.</span>		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">39 Provident Hospital 1514 Division St. Baltimore, Maryland 21217</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>		
13. FATHER'S NAME <span style="font-size: 1.2em;">John Fulton</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Francis Dotson</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Mr. James Brooks (Husband) Same</span>
18. <span style="font-size: 1.2em;">174 X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <span style="font-size: 1.2em;">Abdominal CARCINOMATOSIS WITH ASCITES</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.2em;">CARCINOMA, Rt. BREAST</span> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">None</span>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">June 29, 1968</span> 19 to <span style="font-size: 1.2em;">Aug. 6, 1968</span> 19, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">Aug. 6, 1968</span> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <span style="font-size: 1.2em;">Harold R. Johnson</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">8-7-68</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Harold Johnson, M. D.</span>
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">8-12-68</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Baltimore National</span>
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">AUG 8 1968</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">R. E. Taylor</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Charles R. Law 802 Madison Ave.</span>
24D. LOCATION (City, town, or county) <span style="font-size: 1.2em;">Baltimore, Maryland</span>		24E. LOCATION (State) <span style="font-size: 1.2em;">Maryland</span>		



# FUNERAL DIRECTOR: IMPORTANT

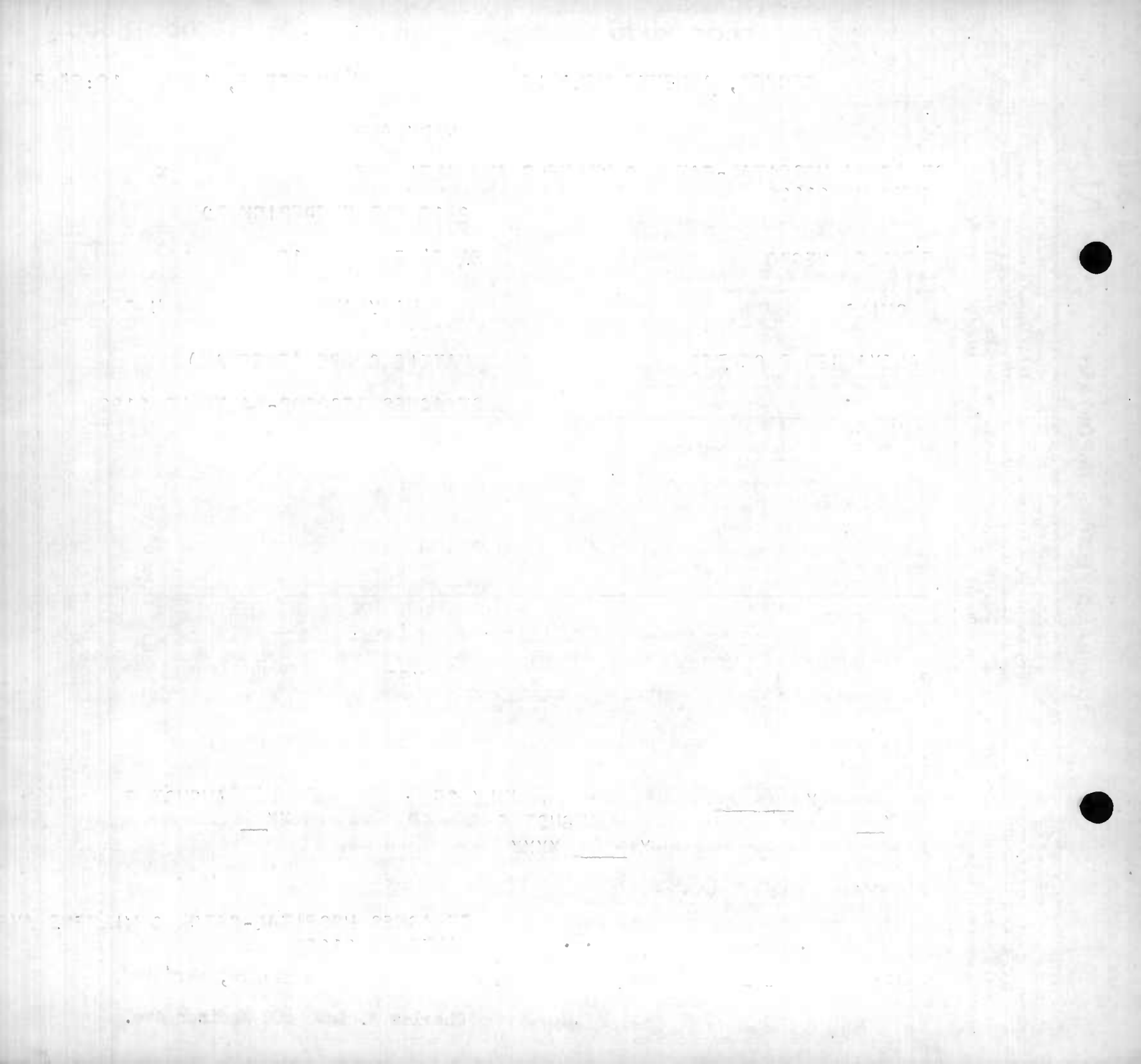
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## 68- 8096 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68- 8096

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>COOPER, ANNETTE MELANIE</b>		2. DATE AND HOUR OF DEATH <b>AUGUST 5, 1968 10:55 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		20-07	
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST AGNES HOSPITAL-CATON &amp; WILKENS AVE BALTO MD 21229</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>3810 OLD FREDERICK RD</b>		5. SEX <b>FEMALE</b>		6. RACE <b>NEGRO</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>02 04 58</b>		9. AGE (In years lost birthday) <b>10</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHILD</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>ALEXANDER P COOPER</b>		14. MOTHER'S MAIDEN NAME <b>MATTIE COOPER(FREEMAN)</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>ST AGNES RECORDS-BALTO MD 21229</b>	
18. <b>23811</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Brain Tumor</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. <b>237X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>BRONCHOPNEUMONIA</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JULY 25 1968</b> to <b>AUGUST 5 1968</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>AUGUST 5 1968</b> and that in my <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE <b>Maria D. Giron M.D.</b>		23B. DATE SIGNED <b>8/6/68</b>			
23C. PHYSICIAN'S NAME (Type) <b>Maria D. Giron M.D.</b>		23D. ADDRESS <b>ST AGNES HOSPITAL-CATON &amp; WILKENS AVE BALTO MD 21229</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-9-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkas</b>	
25C. FUNERAL DIRECTOR <b>Charles R. Law</b>		25D. ADDRESS <b>802 Madison Ave.</b>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8097

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JERRY WILKES</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> <b>8 4 68 6:00 p. M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1842 Lorman St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 4 1968 6:00 p. M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Colored</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>3-6-92</b>		10. AGE (In years lost birthday) <b>76</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles Wilkes</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Wilkes</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>		18. SOCIAL SECURITY NO. <b>218-01-4904</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>162.1 I</b> <b>Carcinoma of the lung</b>		20. DATE OF OPERATION	
21. AUTOPSY? (Yes or No) <b>No</b>		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
23. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		24. HOW DID INJURY OCCUR?	
25. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
27. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		28. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
29. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		30. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
31. ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		32. DATE SIGNED <b>August 5, 1968</b>	
33. 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		34. 24B. DATE <b>8/8/68</b>	
35. 24C. NAME OF CEMETERY OR CREMATORY <b>Balto National Cem.</b>		36. 24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
37. 25A. DATE REC'D BY HEALTH DEPT. <b>AUG 8 1968</b>		38. 25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>	
39. 25C. FUNERAL DIRECTOR <b>Wm C March</b>		40. ADDRESS <b>928 E. North Ave.</b>	

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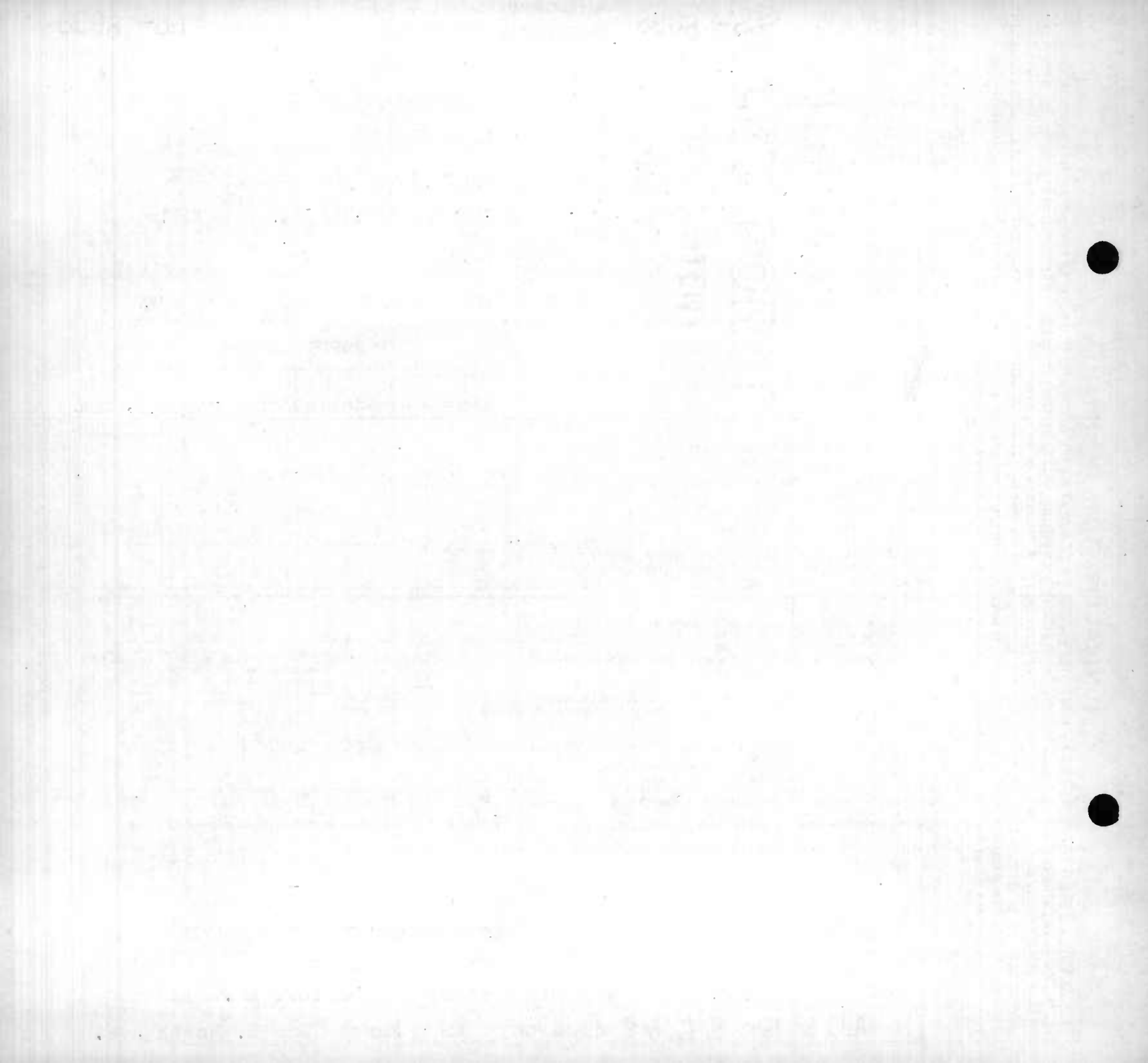
1933-34

WALLEY BOULE

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Pauline Price</i>		2. DATE AND HOUR OF DEATH <i>8/4/68 13:00A</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i> BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				A. STATE MARYLAND C. CITY OR TOWN BALTIMORE E. STREET AND NUMBER 1758 LLEWELLYN AVENUE 21218	
5. SEX FEMALE		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 48	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ISAAC COTTON				14. MOTHER'S MAIDEN NAME ROSIE JONES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MD RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE	
18. <i>070X I</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Hepatic Coma</i>					
(B) <i>Chronic Hepatitis</i> DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6-28</i> 19 <i>68</i> to <i>8-4</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>8-4</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Paul R. Kalcut</i>				23B. DATE SIGNED 8-4-68	
23C. PHYSICIAN'S NAME (Type) DR. PAUL R. KALCUT				23D. ADDRESS BCH-4940 EASTERN AVENUE, BALTIMORE, MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/68		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery	
24D. LOCATION Balto., Md.		24E. NAME OF REGISTRAR <i>Robert E. Feltman</i>		24F. FUNERAL DIRECTOR Wm C March 928 E. North Ave.	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1968		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8099

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 8099

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>August E. Seitz</b>		2. DATE AND HOUR OF DEATH <b>August 6th., 1968</b> <b>6</b> <b>6A</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>7-01</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b>			(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3042 E. Monument Street</b>		C. CITY OR TOWN <b>Baltimore</b>
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>3042 E. Monument Street</b>
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 29, 1899</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
13. FATHER'S NAME <b>Henry Seitz</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b> <b>None</b>			16. SOCIAL SECURITY NO. <b>214-01-9007</b>		
			17. INFORMANT <b>Thomas Collins</b> ADDRESS <b>3685 Dudley W</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>260X</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarction</b> <b>Diabetes Mellitus</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Sengreen at foot</b> (C) <b>arteriosclerosis - senescent</b>		
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>3/7</b> 19 <b>67</b> to <b>8/6</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/3</b> 19 <b>68</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Louis F. Klimes M.D.</b>			23B. DATE SIGNED <b>8/7/68</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>2623 E. Monument St</b>			23D. ADDRESS <b>LOUIS F. KLIMES M.D.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/9/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Carmel Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>5712 O'donnell St. Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 8 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Frederick D. Miller, Inc 3019 Monument St</b>			



BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8100

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>NELLIE HALL BROWN</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>August 5, 1968</b>		Hour <b>4:52 P.M.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1408 School Street (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>August 5, 1968</b>		Hour <b>4:52 P.M.</b>
6. SEX <b>female</b>		7. RACE <b>negro</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH <b>June 7, 1904</b>		10. AGE (In years last birthday) <b>64</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles Hall</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
15. MOTHER'S MAIDEN NAME <b>Julia Barnes</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.
18. INFORMANT <b>James H. Gough</b>		19. ADDRESS <b>1408 School St.</b>		

19. CAUSE OF DEATH <b>Hypertensive Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) DUE TO, OR AS A CONSEQUENCE OF:		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		

20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?

23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>Werner U. Spitz</b>		M.D.		DATE SIGNED <b>8/6/68</b>
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		

24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/9/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 8 1968</b>		25B. NAME OF REGISTRAR <b>R. E. F. J. J.</b>		25C. FUNERAL DIRECTOR <b>Kelson Funeral Home</b>		ADDRESS <b>1348 Calhoun St.</b>	

WALL LEE BOKRIS

Mr. Lee Bokris

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8101 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 68- 8101

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MILDRED F CLOKEY</b>		2. DATE AND HOUR OF DEATH <b>August 4/1968</b> <b>3<sup>55</sup></b> <b>P</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b> <b>44</b>			A. STATE <b>Penn.</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>Pittsburg</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>2000 Cedar Rd Rd 15101</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/13/24</b>	9. AGE (In years lost birthday) <b>43</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
13. FATHER'S NAME <b>JOHN FITZURKA</b>			14. MOTHER'S MAIDEN NAME <del>UNKNOWN</del> <b>Susan Bahim</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. —		17. INFORMANT <b>Weddell F. Hme. Pittsburgh Pa.</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarct</b>  (B) <b>Arteriosclerosis cardiovascularis chronic</b> DUE TO, OR AS A CONSEQUENCE OF: <b>C.S.</b>  (C) —		
19. DATE OF OPERATION <b>4-20-1</b>			20. AUTOPSY? (Yes or No) <b>II</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>July 30 1968</b> to <b>August 4 1968</b> , that (I) (we) last saw the deceased alive on <b>August 4 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Enrique Ellenbogen M.D.</b>			23B. DATE SIGNED <b>8/5/68</b>		
23C. PHYSICIAN'S NAME (Type) <b>ENRIQUE ELLENBOGEN, M.D.</b>			23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/7/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Allegheny Mem. Pk. McCandless Township, Pa.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Seaborn</b>		25C. FUNERAL DIRECTOR <b>James M. Fields - Balt., Md.</b>	

THE UNIVERSITY OF  
ALABAMA

ATTEST: SECRETARY

AT 12:11 A

1. 1971

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 8102 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 8102

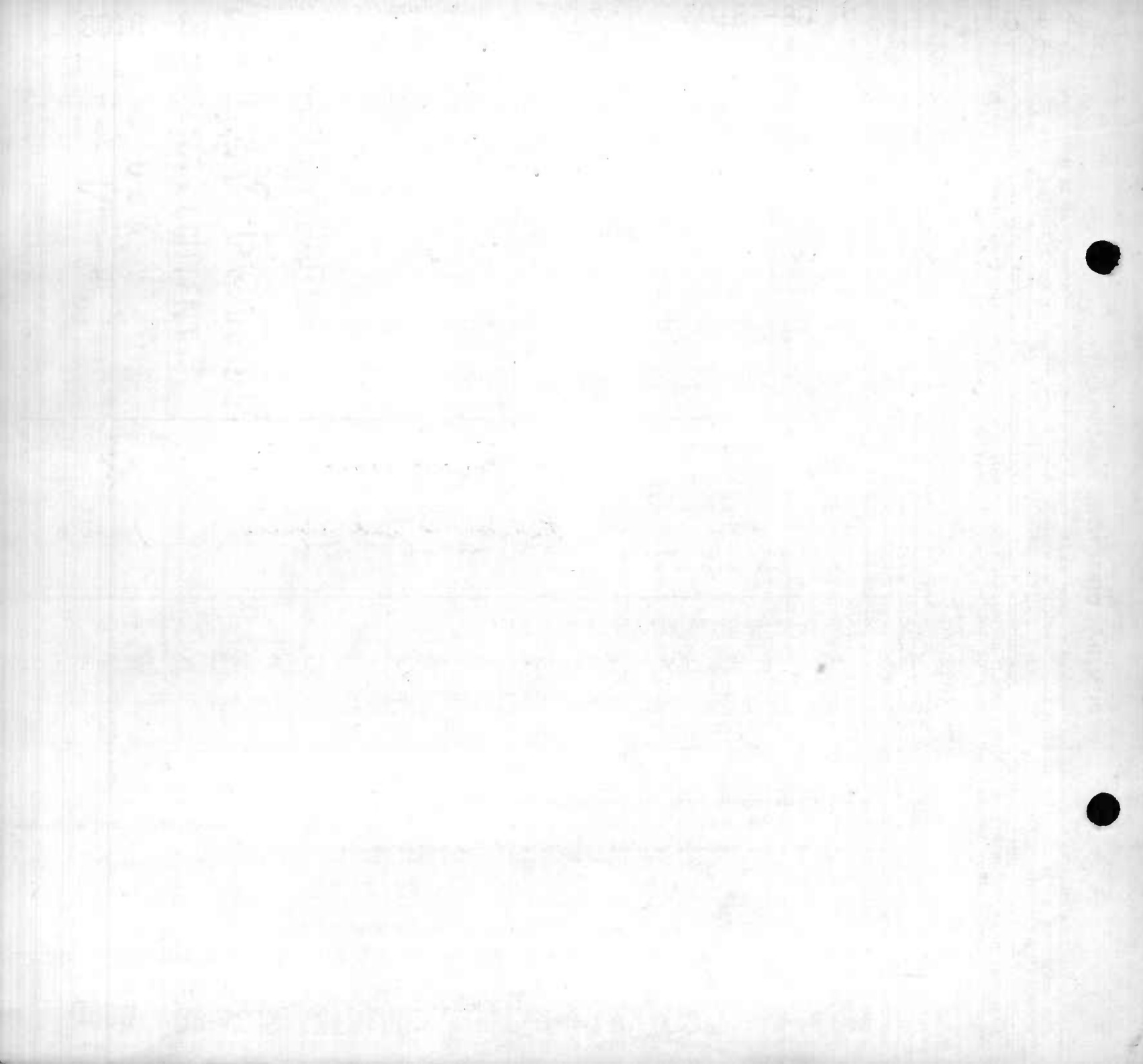
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WILLIAM BROWN		8-4-68 13-45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE	
				MARYLAND	
LUTHERAN HOSPITAL OF MARYLAND				C. CITY OR TOWN	
				BALTIMORE	
16				D. INSIDE CITY LIMITS?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				POPLAR GROVE ST 622	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)
MALE	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	JAN 12, 1898		79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer				Frederick, Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William Brown			Ida Brown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
Yes N N I			162-18-4897		Ms. Lillian Brown 868 Edgewood Ave.
18. CAUSE OF DEATH				ADDRESS	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				Renal failure + Congestive heart failure	
(B) CHRONIC NEPHRITIS + A.S.C.V.D.					
(C).....					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (i) (this hospital) attended the deceased from 6-27-1968 to 8-4-1968, that (I) (we) last saw the deceased alive on 8-3-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
H. Baig				8-4-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8-7-68		Baltimore National	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 8 1968		Robert E. Taylor		Russ Funeral Home 2222 W. North Ave. W.C.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8103	
68- 8103					
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <b>Joseph Burke</b>		2. DATE AND HOUR OF DEATH <b>7-29-68 7<sup>25</sup> pm M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>12-01</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL, INC 42</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>3900 Charles Street</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/15/97</b>	9. AGE (In years last birthday) <b>70</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <b>199.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Carcinomatosis</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>Peritonitis and sepsis</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  <b>?</b>  <b>1 month</b>	
19. <b>199.2 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>July 25/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinomatosis</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 13 1968</b> to <b>July 29 1968</b> , that (I) (we) last saw the deceased alive on <b>July 29 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>July 29/68</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>8-6-68</b>		24C. NAME OF CEMETERY <b>ANATOMY BOARD OF MARYLAND</b>			
24B. DATE		24D. LOCATION (City, town or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR <b>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BMD</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.		68-8104	
<b>1. NAME OF DECEASED</b> (Type or Print) <b>BABY GIRL JOHNSON</b>				<b>2. DATE AND HOUR OF DEATH</b> <b>4-8-68</b> <b>1</b> <b>30</b> <b>P</b> M.			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>Sinai Hospital of Baltimore, Inc.</b>				<b>4. USUAL RESIDENCE</b> (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland.</b> B. COUNTY <b>16-07</b>			
<b>5. SEX</b> <b>F</b> <b>6. RACE</b> <b>N</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>				<b>8. DATE OF BIRTH</b> <b>4-6-68</b> <b>9. AGE</b> (In years lost birthday) <b>0</b>			
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Infant.</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>MARYLAND.</b>			
<b>13. FATHER'S NAME</b> <b>Johnny Johnson.</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Christine [REDACTED] Perry</b>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>			
<b>17. INFORMANT</b> <b>Hospitmo Chart.</b>				<b>ADDRESS</b>			
<b>18. CAUSE OF DEATH</b> <b>I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF:  <b>(B) Prematurity and Immaturity</b> DUE TO, OR AS A CONSEQUENCE OF:  <b>(C)</b>			
<b>19A. DATE OF OPERATION</b> <b>None</b>				<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>			
<b>20A. AUTOPSY?</b> (Yes or No) <b>YES</b>				<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>			
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <b>No</b>				<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)			
<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)				<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)			
<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>4-6-68</b> <b>19 68</b> <b>to</b> <b>4-8-68</b> <b>19</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>4-8-</b> <b>19 68</b> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>							
<b>23A. SIGNATURE</b> <b>Nina C. Rawlings, M.D.</b>				<b>23B. DATE SIGNED</b> <b>4-8-68</b>			
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>NINA C. RAWLINGS, M.D.</b>				<b>23D. ADDRESS</b> <b>Sinai Hospital of Maryland</b>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>				<b>24B. DATE</b> <b>8-6-68</b>			
<b>24C. NAME OF CEMETERY or CREMATORY</b>				<b>24D. LOCATION</b> (City, town, or county) (State) <b>UNIVERSITY MEDICAL SCHOOL</b>			
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>AUG 8 1968</b>				<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Farley</b>			
<b>25C. FUNERAL DIRECTOR</b>				<b>ADDRESS</b> <b>MORTUARY SERVICE - BCHD</b>			



## CERTIFICATE OF DEATH

REG. NO.

68- 8105 ✓

BIRTH NO. 48-13125 68- 8105		2. DATE AND HOUR OF DEATH 7/18/68 3 A.M.	
1. NAME OF DECEASED (Type or Print) <i>Hughes, Baby Girl</i>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Harford Co.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		C. CITY OR TOWN <i>Dalt. Md.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>42 Sinai Hosp.</i>		E. STREET AND NUMBER <i>1001, Chantery Lane</i>	
5. SEX <i>F</i>	6. RACE <i>Can.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/17/68</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	9. AGE (In years last birthday) <i>5</i> 10. If Under 1 Yr. Months <i>5</i> Days <i>30</i> 11. If Under 24 Hrs. Hours <i>30</i> Min.
13. FATHER'S NAME <i>Charles Hughes</i>		14. MOTHER'S MAIDEN NAME <i>Susan</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
18. <i>776.2 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Respiratory Distress syndrome</i> (B) <i>Prematurity</i> DUE TO, OR AS A CONSEQUENCE OF: (C)	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>773.5 II</i>			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <i>Pending</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>9:18 P.M. 7/17/68</i> to <i>3 AM 7/18/68</i> that (I) <i>(we)</i> last saw the deceased alive on <i>7/18</i> 19 <i>68</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(we)</i> (did) (did not) view the body after death.			
23A. SIGNATURE <i>Joseph H. Richman, M.D.</i>		23B. DATE SIGNED <i>7/18/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Joseph H. Richman</i>		23D. ADDRESS <i>Sinai Hosp. Baltimore, Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <i>8-6-68</i>	24C. NAME OF CEMETERY or CREMATORY <i>ANATOMY BOARD OF MARYLAND</i>	24D. LOCATION (City, town, or county) (State) <i>UNIVERSITY MEDICAL SCHOOL</i>
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 8 1968</i>	25B. NAME OF REGISTRAR <i>Robert E. Farber</i>	25C. FUNERAL DIRECTOR	ADDRESS <i>MORTUARY SERVICE - BALTIMORE</i>

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-13125-

879-9491

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-8106
BIRTH NO. 68-12681		68-8106		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) <u>BABY Boy CRAIN</u>		2. DATE AND HOUR OF DEATH <u>July 13 12:10 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Smair Hospital, Balto. Md.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>Balto Co.</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1320 Middleford Rd</u>		
5. SEX <u>M</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-11-68</u>	9. AGE (in years last birthday) <u>42</u> 10. If Under 1 Yr. Months <u>10</u> If Under 24 Hrs. Hours <u>10</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>ROBERT</u>		
14. MOTHER'S MAIDEN NAME <u>IRIS CARDEN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Chart</u> ADDRESS <u>—</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>777X I</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Immaturity</u> (B) <u>Premature delivery</u> (C) <u>—</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Birth</u> <u>Birth</u>
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>776X II</u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>—</u>		
19A. DATE OF OPERATION <u>7-13-68</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>	20A. AUTOPSY? (Yes or No) <u>Yes</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>	21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>—</u>		
22. I certify that (I) (this hospital) attended the deceased from <u>July 11 1968</u> to <u>July 13 1968</u> , that (I) (we) last saw the deceased alive on <u>July 13 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Nina Lawrence MD</u>		23B. DATE SIGNED <u>7-13-68</u>		23C. PHYSICIAN'S NAME (Type) <u>NINA</u>
23D. ADDRESS <u>C. RAWLIN GS MD</u>		23E. ADDRESS <u>Smair Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>—</u>	24B. DATE <u>8-6-68</u>	24C. NAME OF CEMETERY or CREMATORY <u>—</u> 24D. LOCATION (City, town, or county) (State) <u>MARYLAND</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 8 1968</u>	25B. NAME OF REGISTRAR <u>Robert E. Farley</u>	25C. FUNERAL DIRECTOR <u>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</u>		

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

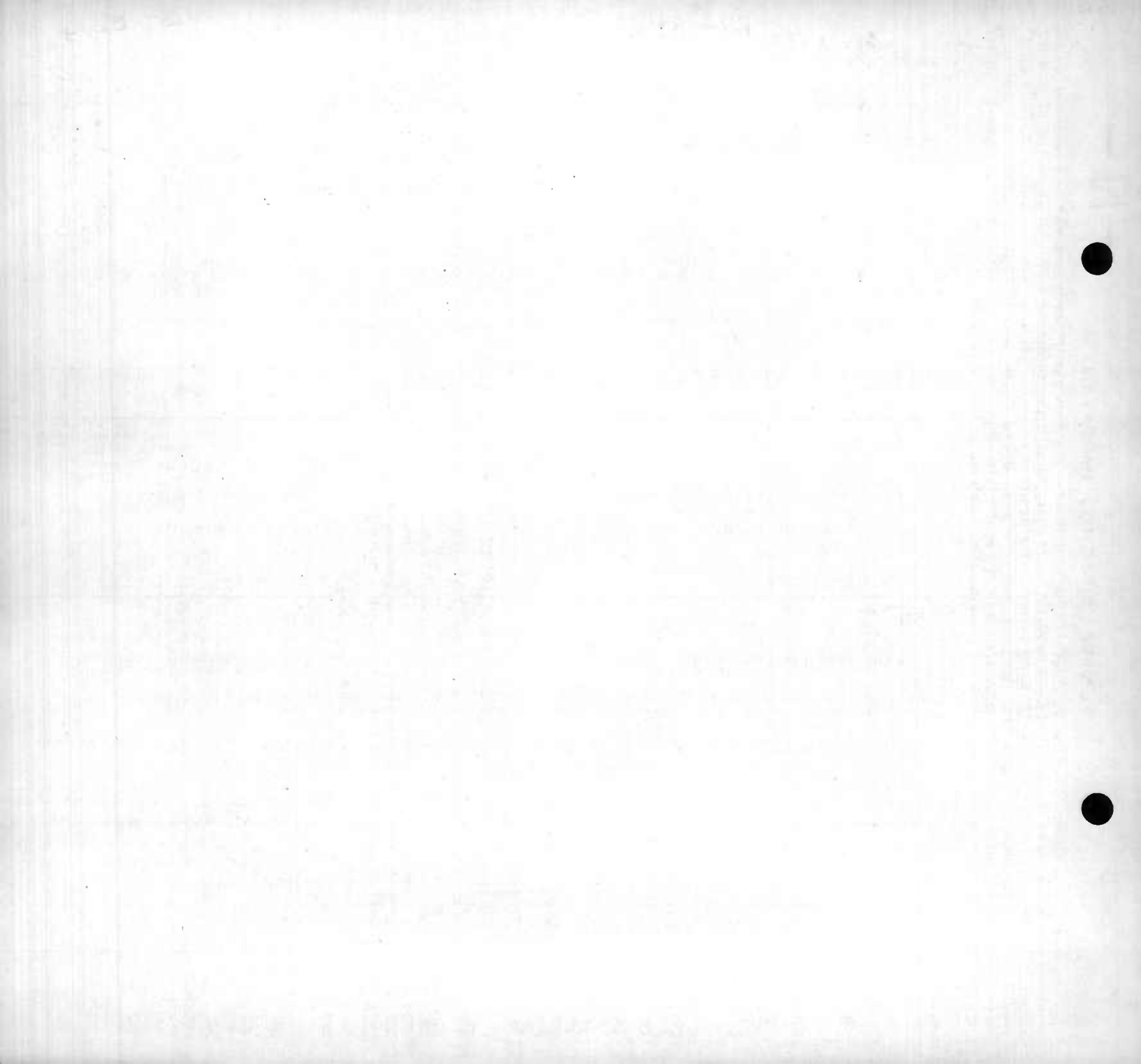
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 8107
BIRTH NO. <b>68-12276</b>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>RAIKES, BABY GIRL</b>		2. DATE AND HOUR OF DEATH <b>7/4/68 2:30 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL OF BALTIMORE, INC.</b>		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>md.</b> B. COUNTY <b>15-12</b>			
5. SEX <b>F</b>		6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/4/68</b>	9. AGE (In years lost birthday) <b>12 40</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>JAMES CARTER</b>		14. MOTHER'S MAIDEN NAME <b>SHEARRAN RAIKES</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>SHEARRAN RAIKES</b> ADDRESS <b>2804 SUFFOLK AVE</b>	
18. <b>777X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>IMMATURITY</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 4 1968</b> to <b>July 4 1968</b> , that (I) (we) last saw the deceased alive on <b>July 4 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>MA. JOSEFINA LB. DE LOS SANTOS MD</b> DEGREE				23B. DATE SIGNED <b>7/4/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>MA. JOSEFINA LB. DE LOS SANTOS MD</b> DEGREE				23D. ADDRESS <b>SINAI HOSPITAL OF BALTIMORE INC. ANA TOB BOARD OF MARYLAND</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>8-6-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>UNIVERSITY MEDICAL SCHOOL</b>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 8 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8108	
BIRTH NO. 68-12569		68- 8108		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Prettyman, Baby Boy		2. DATE AND HOUR OF DEATH 7/7/68 11XP M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 15-01			
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hosp		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 1457 Mountmor Ct #17			
5. SEX M	6. RACE N N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/5/68	9. AGE (In years lost birthday) 2	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. 776.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Aspiration Pneumonia (B) Prematurity (C) Primary Apnea of Newborn		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		762.5 II			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Pending	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 7/5/68 to 7/7/68, that (1) (we) last saw the deceased alive on 7/7/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph H. Richman		23B. DATE SIGNED 7/7/68		23C. PHYSICIAN'S NAME (Type) Joseph H. Richman	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 8-6-68		24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1968		25B. NAME OF REGISTRAR Robert E. Fairman		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

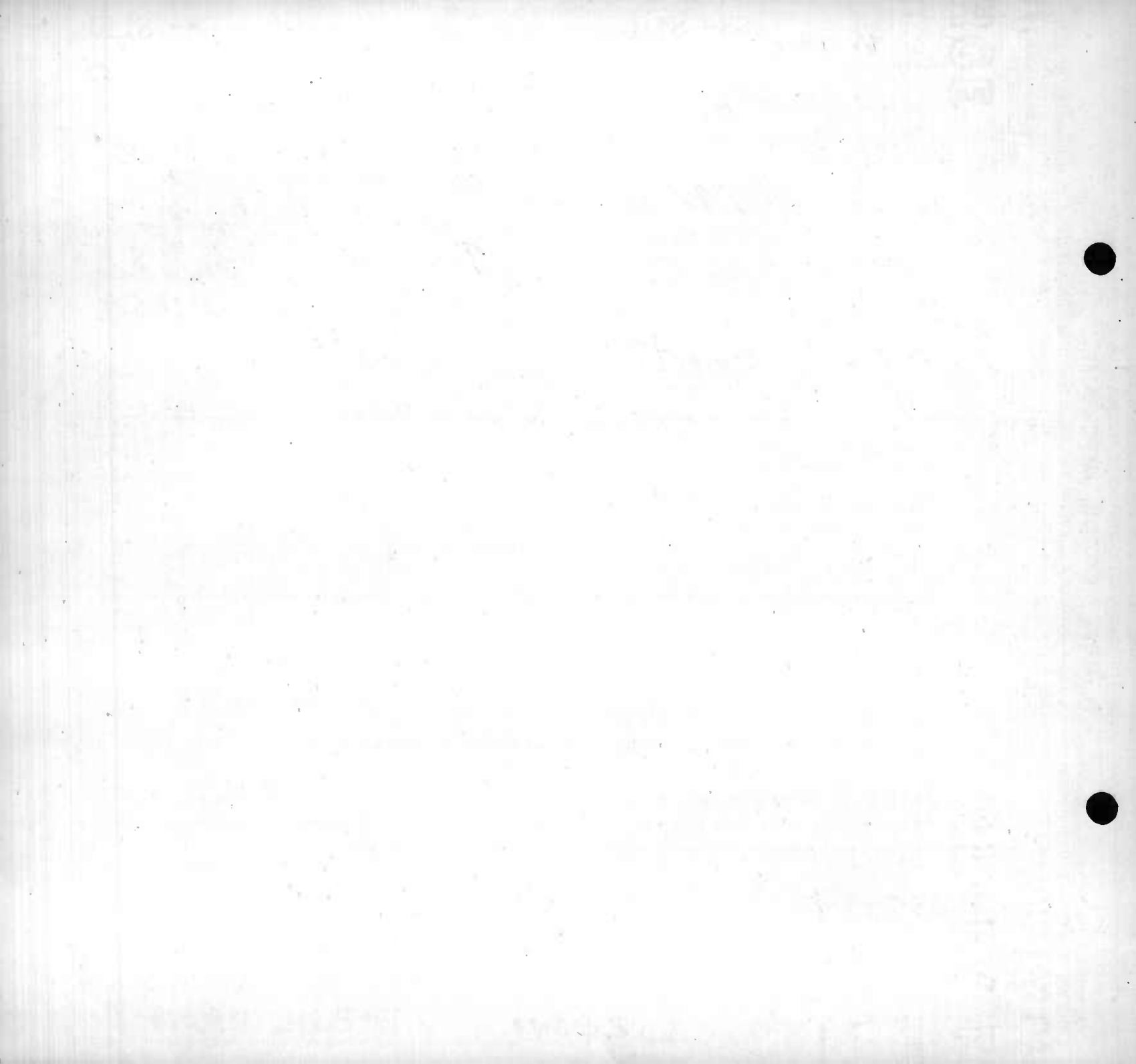
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8109	
BIRTH NO. 68-13067		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Baby Boy PARKER		2. DATE AND HOUR OF DEATH 7-14-68 7:19 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 38 University of Maryland Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 2028 Mt Royal Terrace #474			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-12-68	9. AGE (In years last birthday) 44	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 19
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10B. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Carlton Parker		14. MOTHER'S MAIDEN NAME Jane Williams	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) N/A		16. SOCIAL SECURITY NO. N/A		17. INFORMANT GARY A. Fleming, M.D. UNIV. HOSP.	
18. 776.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Hyaline membrane disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PREMATURITY (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours 19 min 4 hours 17 min	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 773.5 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (his hospital) attended the deceased from 7-13 1968 to 7-14 1968, that (I) (we) last saw the deceased alive on 7-14 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gary A. Fleming, M.D. DEGREE				23B. DATE SIGNED 7-14-68	
23C. PHYSICIAN'S NAME (Type) Gary A. Fleming, M.D. DEGREE				23D. ADDRESS ANATOMY BOARD OF BALTIMORE HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8-7-68		24C. NAME of CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR HOSPITAL DISPOSAL		24F. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1968		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

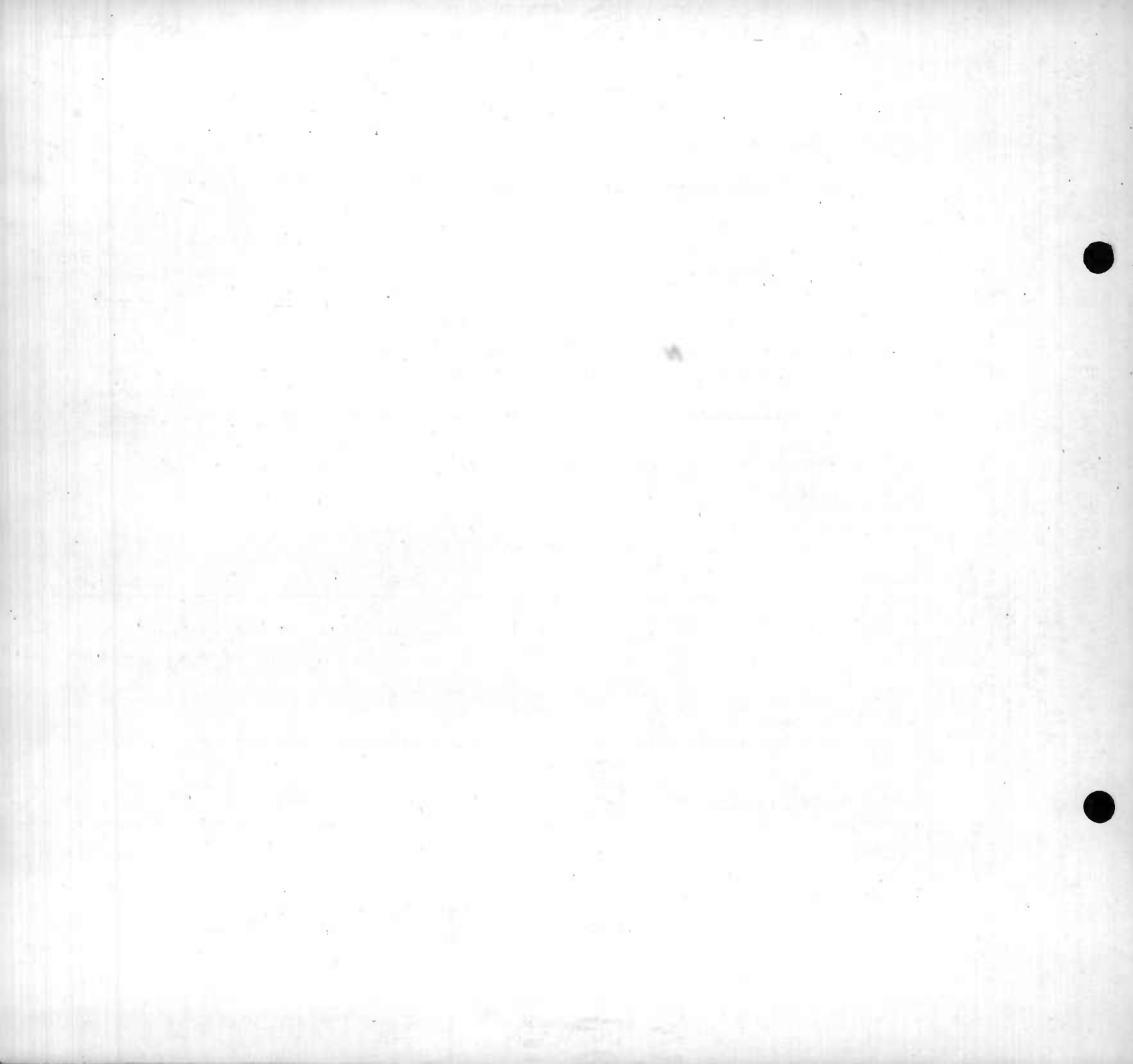
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-8110</b>
BIRTH NO. <b>68-14121</b>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>Baby Boy Smart</b>		2. DATE AND HOUR OF DEATH <b>8/2/68</b> <b>17<sup>00</sup></b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>Univ. of Md Hosp.</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>18-02</b>		
5. SEX <b>male</b>		6. RACE <b>C</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Newborn</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>7-25-68</b>
13. FATHER'S NAME <b>Bernard Smart</b>		14. MOTHER'S MAIDEN NAME <b>Sherry Harris</b>		9. AGE (In years lost birthday) <b>8 days</b> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		6. SOCIAL SECURITY NO.		17. INFORMANT <b>Mother</b> ADDRESS <b>Same</b>
18. <b>486X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, - if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac Failure</b> (B) <b>Aspiration Pneumonia</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 hr</b> <b>8 hr</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>763.0 II</b>				
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>28 July 1968</b> to <b>2 August 1968</b> , that (I) (we) last saw the deceased alive on <b>1 August 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>John K. Weary</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>2 August 1968</b>
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>8-7-68</b>		24C. NAME OF CEMETERY or CREMATORY
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>HOSPITAL DISPOSAL</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

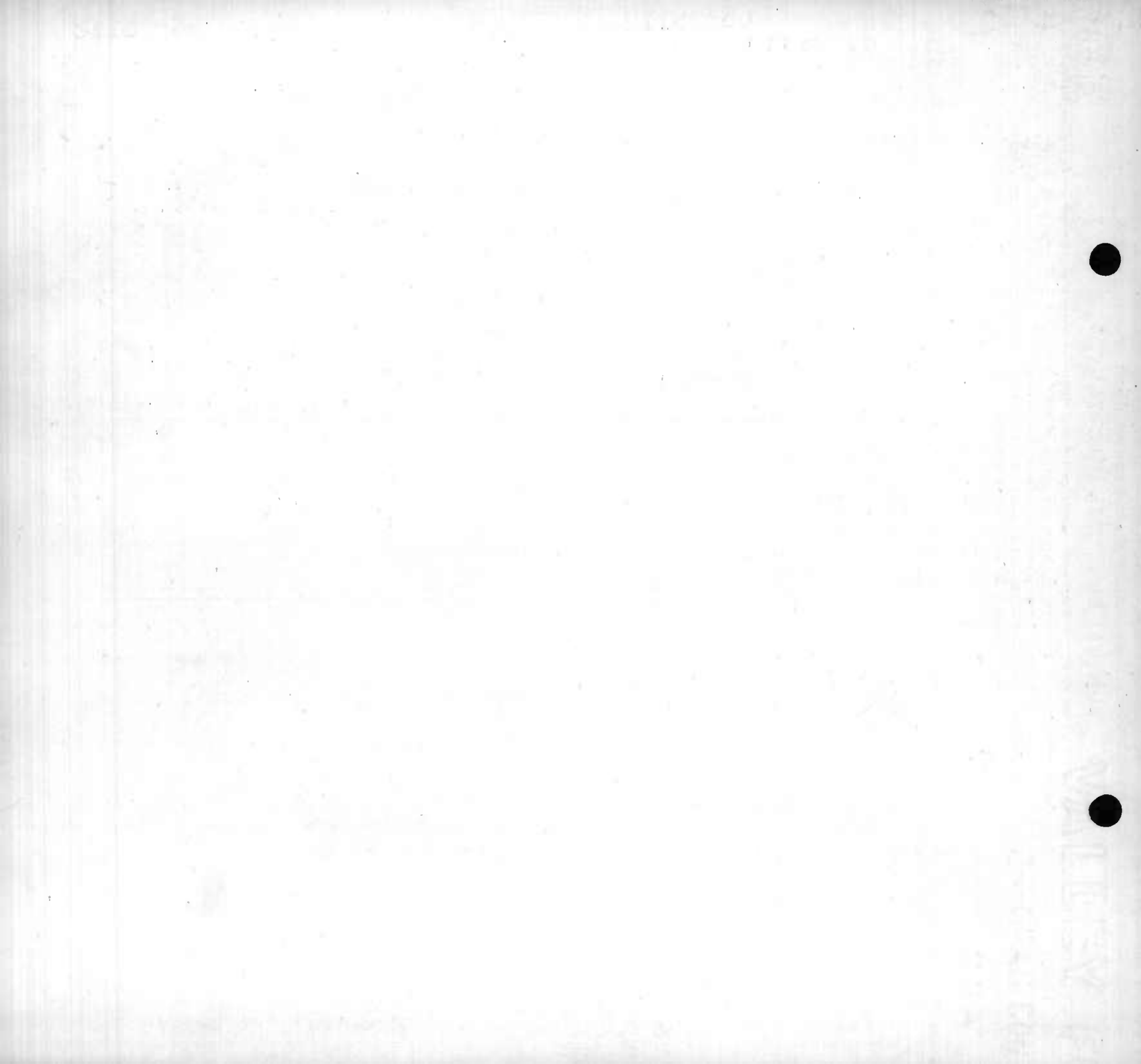
BIRTH NO. <u>68-14127</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>68-8111</u>	
1. NAME OF DECEASED (Type or Print) <u>Baby Girl Stone</u>			2. DATE AND HOUR OF DEATH <u>7-27-68</u> <u>6<sup>05</sup> P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Maryland</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
5. SEX <u>Female</u> 6. RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		X <u>68-04</u>
8. DATE OF BIRTH <u>7-26-68</u> 9. AGE (In years last birthday) <u>25</u> 10. MONTHS <u>1</u> 11. DAYS <u>58</u>			E. STREET AND NUMBER <u>812 Glade St.</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13. FATHER'S NAME <u>Anthony Stone</u>			14. MOTHER'S MAIDEN NAME <u>Glady's Lynch</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>GARY A. FLEWING</u> ADDRESS <u>University of Maryland</u>
18. <u>7664 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Hyaline Membrane Disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>25 hours</u> <u>58 minutes</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) <u>Prematurity</u> <u>25 hours</u> <u>58 minutes</u> (C) <u>Frank Breach</u> <u>25 hours</u> <u>58 minutes</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>773.5 II</u> <u>Premature rupture of membranes</u>			<u>3 days</u>		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? <u>—</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>7-26</u> 19 <u>68</u> to <u>2-27</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7-27</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>GARY A. FLEWING, M.D.</u> DEGREE <u>—</u>				23B. DATE SIGNED <u>7-27-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>GARY A. FLEWING, M.D.</u> DEGREE <u>—</u>				23D. ADDRESS <u>University of Maryland</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>8-7-68</u>		24B. DATE <u>8-7-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>ANATOMY BOARD OF MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 8 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>UNIVERSITY MEDICAL SCHOOL</u> ADDRESS <u>HOSPITAL DISPOSAL</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>68- 8112</b>	
BIRTH NO. <b>68-12881</b>		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>Bob, Aine Williams</b>		2. DATE AND HOUR OF DEATH <b>7-17-68</b> <b>6 35 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY of Maryland Hosp.</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2743 Raymon Avenue</b>	
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-12-68</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Williams</b>		14. MOTHER'S MAIDEN NAME <b>Hannah Williams</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT <b>GARY A. Fleming, M.D. UNIV. HOSP.</b> ADDRESS	
18. <b>777X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>IMMATURITY</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>776X II</b>			
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>NO</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7-12-68</b> to <b>7-17-68</b> , that (I) (we) lost saw the deceased alive on <b>7-17-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Gary A. Fleming, M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <b>7-17-68</b>
23C. PHYSICIAN'S NAME (Type) <b>GARY A. FLEMING M.D.</b>		23D. ADDRESS <b>UNIV. of Maryland Hosp.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <b>8-7-68</b>	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
		<b>ANATOMY BOARD OF MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbanks</b>	25C. FUNERAL DIRECTOR ADDRESS <b>HOSPITAL DISPOSAL</b>



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

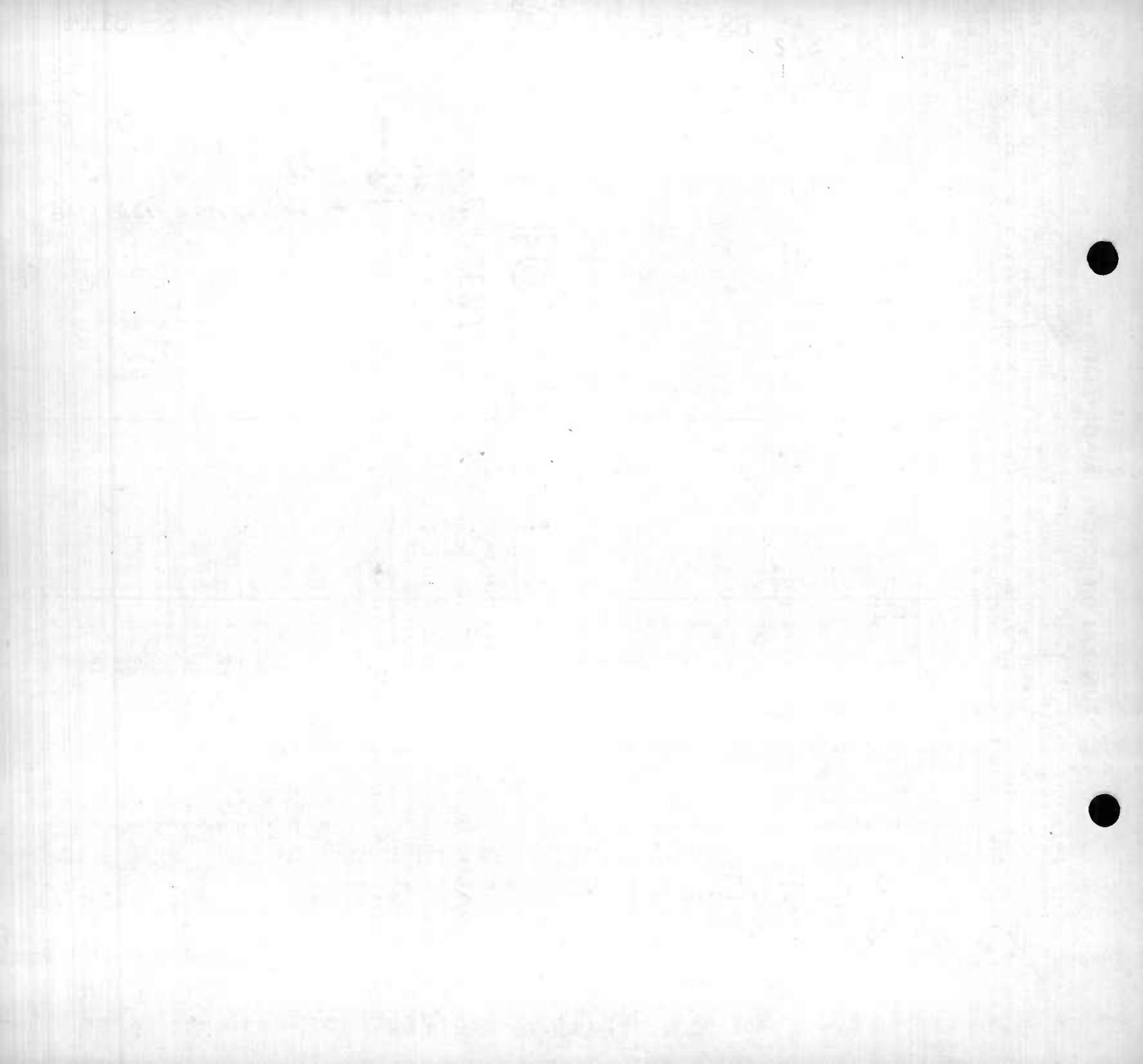
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68- 8113 4</b>
BIRTH NO. <b>68- 8113</b>				
1. NAME OF DECEASED (Type or Print) <b>BABY BOY COFFEE</b>		2. DATE AND HOUR OF DEATH <b>8/4/68</b> <b>12:04</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIVERSITY HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1626 Booker Ct.</b>		
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/3/68</b>	9. AGE (In years lost birthday) <b>24</b> min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NEW BORN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>IRVIN JOHN FRANKLIN</b>		
14. MOTHER'S MAIDEN NAME <b>MARY THOMAS</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>MOTHER</b> ADDRESS <b>1626 BOOKER CT. BALTIMORE</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>777X I</b> <b>IMMATURE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>776X II</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Immaturity</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>0</b>		19A. DATE OF OPERATION <b>0</b>		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>3 August</b> 19 <b>68</b> to <b>4 August</b> 19 <b>68</b> that (I) (we) last saw the deceased alive on <b>4 August</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>J. K. Neely</b>		23B. DATE SIGNED <b>4 August 1968</b>		23C. PHYSICIAN'S NAME (Type) <b>—</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>8-7-68</b>		24B. DATE <b>8-7-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>UNIVERSITY MEDICAL SCHOOL</b>
24D. LOCATION (City, town, or County) (State) <b>HOSPITAL DISPOSAL</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 8 1968</b>		
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>HOSPITAL DISPOSAL</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8114	
BIRTH NO. 68-13136		68- 8114		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Baby Boy Ruth			2. DATE AND HOUR OF DEATH 7-16-68 10 <sup>30</sup> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE B. COUNTY Baltimore 53-00		
FULL NAME OF HOSPITAL OR INSTITUTION Sina. Hosp. 42			(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTO. MD
					D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 7926 ST MONICA DRIVE		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-14	9. AGE (In years lost birthday) 2	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Balt.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Mr. Ruth			14. MOTHER'S MAIDEN NAME DELORES RUTH		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
18. 776.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Prematurity (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  Hyaline Membrane Disease (B) DUE TO, OR AS A CONSEQUENCE OF:  asphyxia (C) _____		
19A. DATE OF OPERATION 7-2-68			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II		
19C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert Suskind MD			23B. DATE SIGNED 7-16-68		23C. PHYSICIAN'S NAME (Type) Robert Suskind MD
23D. ADDRESS BALTIMORE BOARD OF MARYLAND			23E. UNIVERSITY MEDICAL SCHOOL		
24A. BURIAL CREMATION, REMOVAL (Specify) 8-6-68			24B. DATE 8-6-68		
24C. NAME OF CEMETERY or CREMATORY AUG 3 1968			24D. LOCATION (City, town, or county) (State)		
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1968			25B. NAME OF REGISTRAR Robert E. Johnson		
25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD			25D. ADDRESS		



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 8115

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>ALPHONSE JORDAN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>August 6, 1968</b> 7:45 AM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>0510 E. Fort Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 6, 1968 10:40 AM</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>24-02</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>5/10/1906</b>		10. AGE (In years lost birthday) <b>62</b>	
11. BIRTHPLACE (State or foreign country) <b>Brooklyn, NY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Salvatore Giordano</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Columbo</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Employed City</b>		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		18. SOCIAL SECURITY NO. <b>213-05-7714</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>E955 X1</b>		20. CAUSE OF DEATH <b>Gunshot Wound of Abdomen</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>#7</b>	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>E976 X II</b>		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
23A. DATE OF OPERATION <b>0</b>		23B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
24A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		24B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>	
24C. WHERE DID INJURY OCCUR? <b>510 E. Fort Avenue</b>		24D. HOW DID INJURY OCCUR? <b>Subj. shot self in abdomen</b>	
24E. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.) <b>8/6/68 bet. 7:45 A. &amp; 10:15 A.</b>		24F. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
25. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <b>8/6/68</b>	
26A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		26B. DATE <b>6-8-68</b>	
26C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cem.</b>		26D. LOCATION (City, town, or county) (State) <b>Balto, Md.</b>	
27A. DATE REC'D BY HEALTH DEPT. <b>AUG 8 1968</b>		27B. NAME OF REGISTRAR <b>Robert E. Farber</b>	
27C. FUNERAL DIRECTOR <b>Ellsworth Armacost</b>		27D. ADDRESS <b>4600 Liberty Hgts. Ave.</b>	

Wm. L. ...

F-422

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8116

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOHN FOWLKES</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 5, 1968 Hour: 9:15 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year August 5, 1968 Hour: 9:15 P.M.	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Dec 25, 1907</b>		10. AGE (In years last birthday) <b>60</b>	
11. BIRTHPLACE (State or foreign country) <b>Mecherlin Va.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Burrell Fowlkes</b>		14. MOTHER'S MAIDEN NAME <b>Polly ?</b>	
15. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Elizabeth Fowlkes</b> ADDRESS <b>715 Sterling St</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>E 880 X I</b>		CAUSE OF DEATH <b>Multiple Traumatic Injuries</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20. DATE OF OPERATION		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>hospital</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Johns Hopkins Hospital</b>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>August 4, 1968 UNK</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>subj. fell down the steps</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <b>Werner U. Spitz, M.D.</b> EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>8/6/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug 10/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Abraham Mem Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>	
25C. FUNERAL DIRECTOR <b>John T. Tolson</b>		25D. ADDRESS <b>1129 N. Carroll St</b>	

James W. [Signature]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68- 8117</b>	
<div style="display: flex; justify-content: space-between;"> <span><b>G-450</b></span> <span><b>68- 8117</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>LULA GLENN</b>			<b>2. DATE AND HOUR OF DEATH</b> <b>8-3-68</b> <b>5:30 P</b> <small>M.</small>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BOLTON HILL NURSING CENTER</b> <b>70</b>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY _____  C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>8.07</b>  E. STREET AND NUMBER <b>1302 N. BROADWAY</b>		
<b>5. SEX</b> <b>F</b>	<b>6. RACE</b> <b>N</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>9/ / 82</b>	<b>9. AGE</b> (In years last birthday) <b>85</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			<b>11. BIRTHPLACE</b> (State or foreign country) <b>VA.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>
<b>13. FATHER'S NAME</b> <b>WASHINGTON, SELS</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>MARY HILL</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>ADMISSION RECORD</b> <b>ADDRESS</b>
<b>18. CAUSE OF DEATH</b> <div style="display: flex;"> <div style="flex: 1;"> <b>412.4 I</b>  <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                 </div> <div style="flex: 1;"> <b>(A) IMMEDIATE CAUSE</b>  <b>Prothrombotic Cardiovascular disease &amp; Peptic Ulceral Thrombosis</b>   <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b>   <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b> </div> <div style="flex: 0.5;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  <b>Months</b> </div> </div>					
<b>422.1 II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>					
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (1) (this hospital) attended the deceased from <u>Nov 24</u> 19<u>67</u> to <u>August 3</u> 19<u>68</u>, that (2) (we) last saw the deceased alive on <u>August 3</u> 19<u>68</u> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> 				<b>23B. DATE SIGNED</b>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>H.C. ALVAREZ, MD</b>				<b>23D. ADDRESS</b> <b>1209 SA. Paul SA. Baltimore Md</b>	
<b>24A. BURIAL CREATION, REMOVAL</b> (Specify)		<b>24B. DATE</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b>	
<b>24A.</b> <b>Burial Aug 9/68</b>		<b>24B.</b> <b>Aug 9/68</b>		<b>24C.</b> <b>McAuburn Cem</b>	
<b>24D. LOCATION</b> (City, town, or county) (State)		<b>24D.</b> <b>Westport Md.</b>			
<b>25A. DATE REC'D BY HEALTH DEPT.</b>		<b>25B. NAME OF REGISTRAR</b>		<b>25C. FUNERAL DIRECTOR</b>	
<b>AUG 8 1968</b>		<b>Robert E. Taylor</b>		<b>Elmwood Funeral Home</b>	



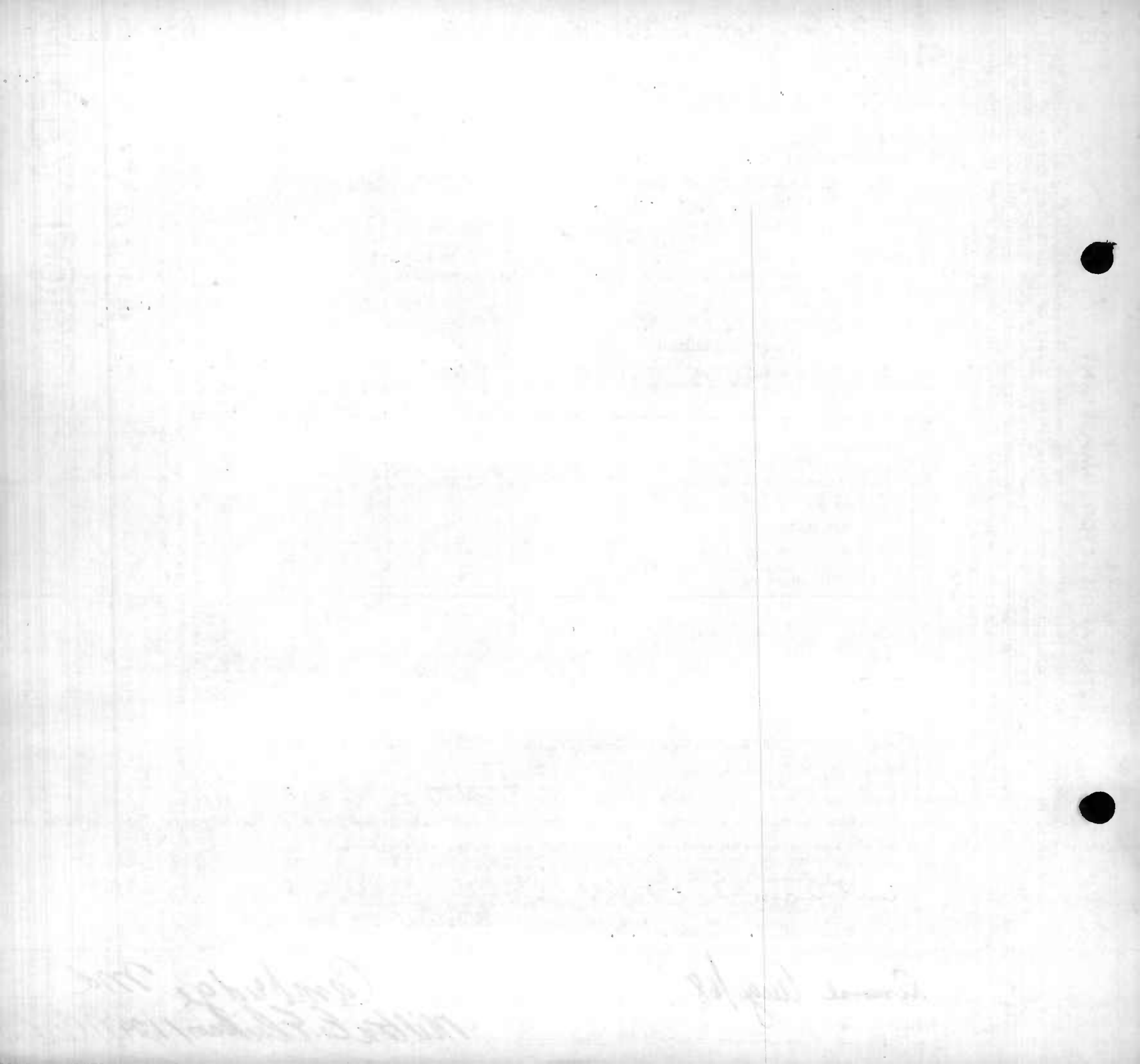
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-8118	
A-53 68-8118				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		DATE AND HOUR OF DEATH	
		Irene Anderson (nee Allen)		11:40 pm August 4 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
				A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN	
BALTIMORE CITY HOSPITALS				BALTIMORE	
4940 Eastern Ave., Balto., Md. #21224				D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE Negro		8. DATE OF BIRTH 9-15-1910	
		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years lost birthday) 57	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Virginia	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?	
Allen Thomas Hurt.				U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No.				BCH RECORDS: 4940 Eastern Ave. Baltimore, Maryland #21224	
18. 183.0 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Metastasis of ovarian Cancer 2 months	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(C) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
19A. DATE OF OPERATION MAY 9 1968		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Door		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 7/29 19 68 to 8/4/ 19 68 that (I) (we) last saw the deceased alive on 8/4/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Ho-Kwon CHO, M.D. DEGREE				Aug 4 1968	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Ho-Kwon CHO, M.D. DEGREE				4940 Eastern Ave., Balto., Md. Baltimore city Hospital #21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Removal Aug 8/68				24D. LOCATION (City, town, or county) (State)	
				Farmville Va	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 8 1968		Robert E. Taylor		Special T. E. Dickson 1129 N. Center St	



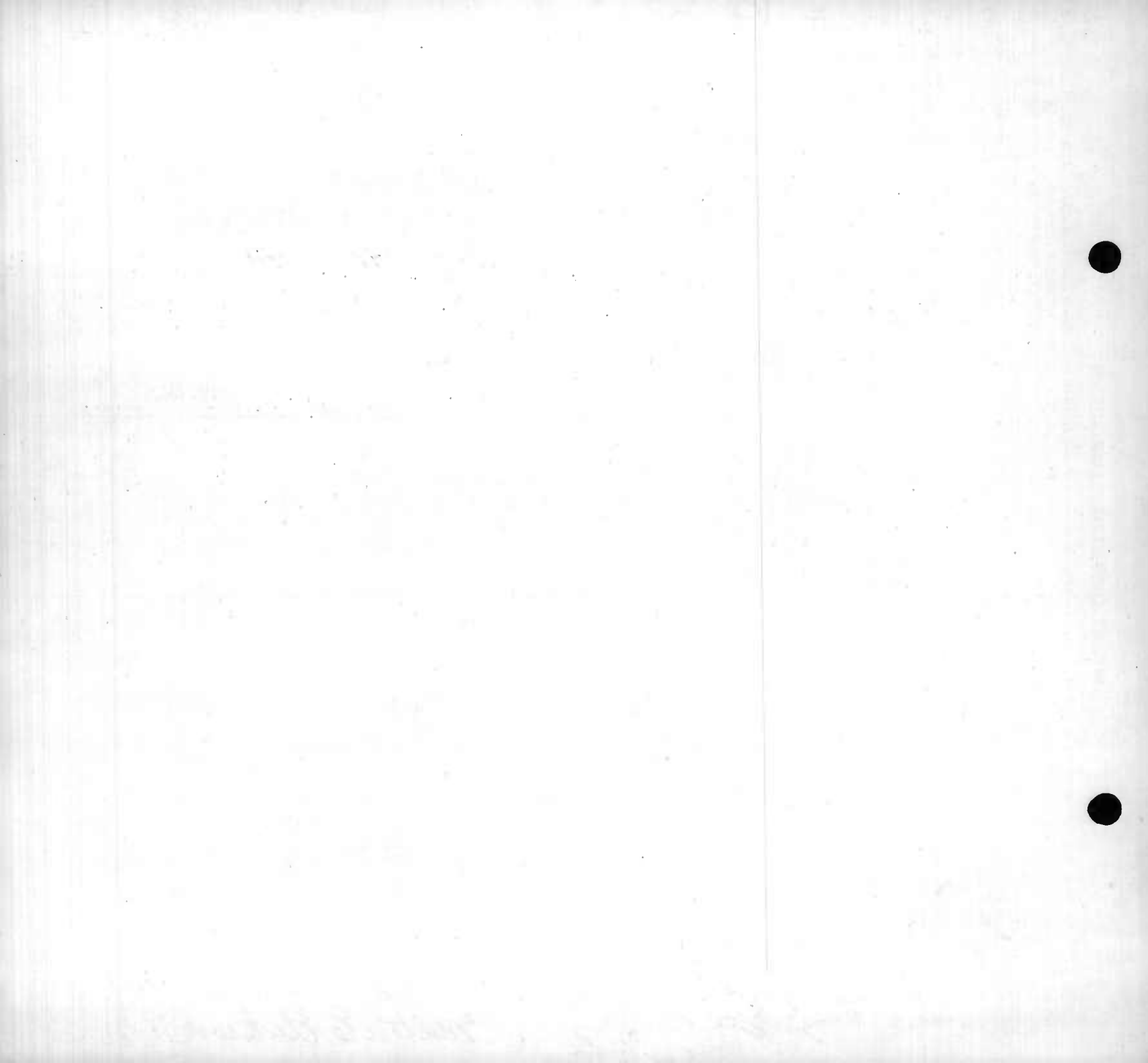
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-610 68- 8119				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 8119	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>EVELYN SHARP</b>		2. DATE AND HOUR OF DEATH 8 - 2 - 68 7:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1800 Caroline St. #21224</b>			
5. SEX <b>Female</b>		6. RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-3-11</b>	
9. AGE (In years lost birthday) <b>57</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Tony Pritchett</b>		14. MOTHER'S MAIDEN NAME <b>Lula Phillips</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>BCH Records: 4940 Eastern Avenue</b> <b>Baltimore, Maryland #21224</b>		ADDRESS	
18. <b>250.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>DIABETES MELLITUS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Right High Thigh Amputation</b>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>260X II</b>							
19A. DATE OF OPERATION <b>6-30-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Clostridial Myositis</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>6/27/19 68</b> to <b>8/2/19 68</b> , that (I) (we) last saw the deceased alive on <b>8/2/68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>William E. Powers, M.D.</b>				23B. DATE SIGNED <b>8/2/68</b>			
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM E. POWERS, M.D.</b>				23D. ADDRESS <b>BCH: 4940 Eastern Avenue</b> <b>Baltimore, Maryland #21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>Remove Aug 1/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>John Wesley Cem Cambridge Md</b>		24D. LOCATION (City, town, or county) (State) <b>Cambridge Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 8 1968</b>		25B. NAME OF REGISTRAR <b>John E. Johnson</b>		25C. FUNERAL DIRECTOR <b>Milton E. Flicker</b>		ADDRESS <b>1229 N. Caroline</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8120			
1. NAME OF DECEASED (Type or Print) <b>JOE WHITE</b>				2. DATE AND HOUR OF DEATH <b>8/7/68</b> <b>112<sup>55</sup> A M.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTIMORE</b>				D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALTIMORE CITY HSOPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND #21224</b>				E. STREET AND NUMBER <b>1802 EAST BIDDLE STREET</b>							
5. SEX <b>MALE</b>		6. RACE <b>NERGO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug 1, 1917</b>		9. AGE (In years last birthday) <b>51</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTH PLACE (State or foreign country) <b>SOUTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAKE WHITE</b>				14. MOTHER'S MAIDEN NAME <b>JANIE</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>RECORDS: BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b>		ADDRESS <b>#21224</b>			
18. <b>380 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE RENAL FAILURE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>PRE-RENAL AZOTEMIA</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ACUTE RENAL FAILURE</b> (B) <b>PRE-RENAL AZOTEMIA</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>373 X II</b> <b>AGNOSTIC MYELOID METAPLASIA</b>											
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <b>July 30th</b> 19 <b>68</b> to <b>August 7th</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>August 7th</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>V. Valdmann MD</b>						23B. DATE SIGNED <b>8/7/68</b>					
23C. PHYSICIAN'S NAME (Type) <b>V. VALDMANN M.D.</b>						23D. ADDRESS <b>BALTIMORE CITY HOSPITALS 4940 EASTERN AVE</b>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>Aug 8, 1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem Park</b>		24D. LOCATION (City, town, or county) (State) <b>Arbutus Md</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 8 1968</b>				25B. NAME OF REGISTRAR <b>Robert E. Fisher, MD</b>				25C. FUNERAL DIRECTOR <b>Melton E. Ellickson</b>			
				ADDRESS <b>11247 N. Carlisle</b>							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-8121	
1. NAME OF DECEASED (Type or Print) <b>DORSEY FREDERICK W.</b>				2. DATE AND HOUR OF DEATH <b>8-7-68</b>   <b>10:20</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND - BALTIMORE</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>49 UNION MEMORIAL HOSPITAL</b>				C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <b>2958 HARFORD ROAD</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12</b> <b>12-16-18#</b>	9. AGE (In years lost birthday) <b>55</b>	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>WILLIAM T. DORSEY</b>				14. MOTHER'S MAIDEN NAME <b>MATHILDA HEIL</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>216-32-2914</b>		17. INFORMANT <b>FREDERICK DORSEY JR.</b>	
18. <b>4-10-91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Infarction</b> <b>Acute Myocardial</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Infarction</b> <b>Acute Myocardial</b>		ADDRESS <b>9121 COVERED</b> <b>BRIDGE ROAD</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>420.1 II</b>				<b>P.L.</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8-5</b> 19 <b>68</b> to <b>8-7</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8-7</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>D. Alvarez</b>				23B. DATE SIGNED <b>8-7-68</b>		23C. PHYSICIAN'S NAME (Type) <b>D. MIRTHA ALVAREZ</b>	
23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/10/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc.</b>		ADDRESS <b>5305 Harford Rd 21214</b>	

W. H. HARRISON

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Union Memorial Hospital

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W. H. HARRISON

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8122	
BIRTH NO. 5-520		68- 8122 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Edward C. Jones</i>		2. DATE AND HOUR OF DEATH <i>August 7, 1968</i> 5 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>27-03</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>2604 Halcyon Ave.</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>male</i>		6. RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Employee</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Koester's Bakery</i>		8. DATE OF BIRTH <i>1-11-1894</i>	
13. FATHER'S NAME <i>Edward D. Jones</i>		14. MOTHER'S MAIDEN NAME <i>Ada Gettier</i>		9. AGE (In years last birthday) <i>74</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes WW I</i>		16. SOCIAL SECURITY NO. <i>212106461</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
17. INFORMANT <i>Marie C. Jones</i>		ADDRESS <i>same</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of lung</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinoma of lung</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST. <i>163X II</i>		(B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>May 3 - 1968</i> to <i>aug 7 - 1968</i> , that (I) (we) last saw the deceased alive on <i>aug 7 - 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>George Sawyer M.D.</i>		23B. DATE SIGNED <i>8/7/68</i>		23C. PHYSICIAN'S NAME (Type) <i>GEORGE SAWYER M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/10/68.</i>		24C. NAME OF CEMETERY or CREMATORY <i>Loudon Park Cemetery</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 8 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc Baltimore, Md.</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		24E. ADDRESS		24F. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-8123	
BIRTH NO. 320				68-8123	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
JUDY A. MIDDAGH			AUG. 7, 1968 7 38 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL 33			A. STATE MD. B. COUNTY Baltimore 53-00		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
BALTIMORE			YES <input type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER			CJ 441 RANGE RD 21204		
5. SEX F		6. RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/7/40		9. AGE (In years lost birthday) 28	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		OWN HOME		PENNA. -	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Milton H. Sheffer		BETTY LOGAN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
NO		16. SOCIAL SECURITY NO. 161-32-3279		17. INFORMANT (NAME) ADDRESS	
CAPT. THOMAS R. MIDDAGH		18. 340X I CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		7 YEARS	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		MULTIPLE SCLEROSIS		(B) DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		(C) DUE TO, OR AS A CONSEQUENCE OF:		(D) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		345X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
ASPIRATION PNEUMONIA		19A. DATE OF OPERATION 7/29/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TRACHEOTOMY - RESPIRATORY ARREST	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (this hospital) attended the deceased from MAY 8, 1968 to AUGUST 7, 1968, that (I) last saw the deceased alive on AUGUST 6, 1968, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) view the body after death.	
23A. SIGNATURE Michael D. Lutz, M.D.		23B. DATE SIGNED Aug 7, 1968		23C. PHYSICIAN'S NAME (Type) MICHAEL D. LUTZ, M.D.	
23D. ADDRESS		23E. DATE		23F. NAME OF CEMETERY or CREMATORY	
JOHNS HOPKINS HOSP.		8/9/68		Dulaney Valley Mem. Grds.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. LOCATION (City, town, or county) (State)		24C. DATE REC'D BY HEALTH DEPT. AUG 8 1968	
Timonium, Balto. Co., Md.		24D. NAME OF REGISTRAR Robert E. Jenkins		24E. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.	

MICHAEL D. LUTS, M.D.

JOHN HOPKINS HOSP

MICHAEL D. LUTS, M.D.

AUGUST 6, 1968

WAS 8, 1968

1968 - AUGUST 1

7/29/68

TRANSCRIPTION - NEW REPORT

YES

EXPERIMENTAL

EXPERIMENTAL

EXPERIMENTAL

EXPERIMENTAL

PERMANENT

EXPERIMENTAL

EXPERIMENTAL

X

7/7/68

C. J. HILL HANCOCK RD

EXPERIMENTAL

EXPERIMENTAL

FUNERAL DIRECTOR: IMPORTANT

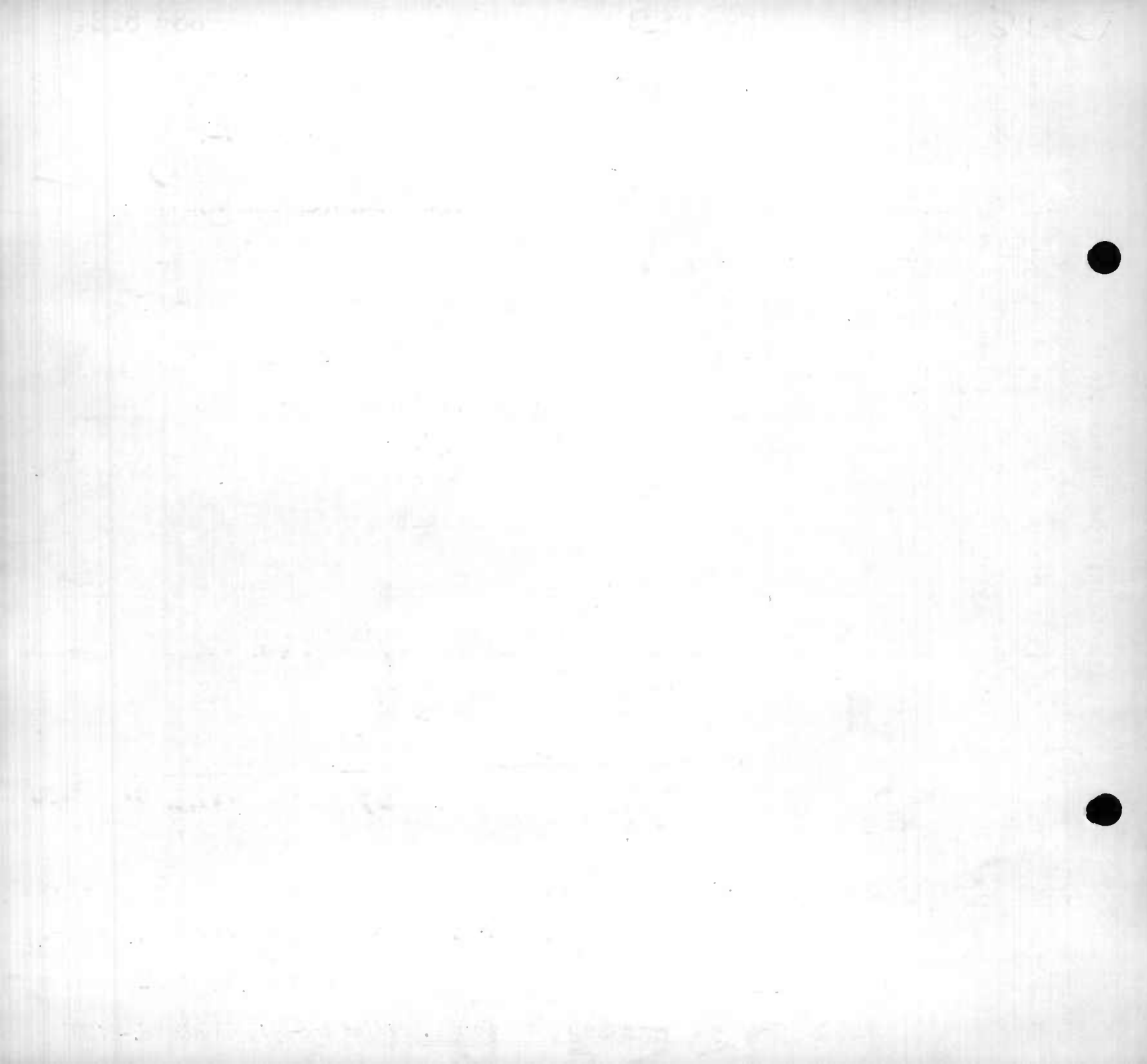
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8124

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 8124

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JOSEPH Elmer BEEVER</b>		2. DATE AND HOUR OF DEATH <b>AUGUST 4, 1968 2:00 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND GENERAL HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? <b>YES</b> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3712 ELMLEY AVENUE</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-4-98</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown - retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>JOSEPH E. BEEVER</b>		
14. MOTHER'S MAIDEN NAME <b>ELLEN B. WALKER</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>212-10-3764A</b>			17. INFORMANT ADDRESS <b>PATIENT</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>15331</b>		CAUSE OF DEATH <b>Metastatic adenocarcinoma of the sigmoid colon</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Severe Coronary artery insufficiency</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>15331 II</b>		19A. DATE OF OPERATION <b>7-23-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Sigmoid carcinoma</b>	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>June 27, 1968</b> to <b>Aug 4, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 4, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <b>Charles S. Harrison, MD</b>		23B. DATE SIGNED <b>8-4-68</b>		23C. PHYSICIAN'S NAME (Type) <b>MARYLAND GENERAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-7-68</b>		24C. NAME of CEMETERY or CREMATORY <b>Morland Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, MA</b>	
25C. FUNERAL DIRECTOR <b>John C. Miller Inc-6415 Belair Rd.-21206</b>		25D. ADDRESS		25E. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 8125 4
BIRTH NO. <u>68-13929</u>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <u>BABY GIRL KASTEN</u>		2. DATE AND HOUR OF DEATH <u>7 - 23 - 68   2:40 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL OF 42 BALTIMORE</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u> 53-00			
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1264 Circle Dr.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-22-68</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. <u>15 /</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>ROD KASTEN</u>		14. MOTHER'S MAIDEN NAME <u>MARY BOOTH</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>CHART</u> ADDRESS	
18. <u>777X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>Immaturity</u> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) <u>Premature Delivery</u> DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7-22</u> 19 <u>68</u> to <u>7-23</u> 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>7-23</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ma. Josefin B. de los Santos</u>		23B. DATE SIGNED <u>7-23-68</u>		23C. PHYSICIAN'S NAME (Type) <u>MD. JOSEFINA LB. DE LOS SANTOS</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>8-668</u>		24B. DATE <u>8-668</u>		24C. NAME of CEMETERY or CREMATORY <u>ANATOMY BOARD OF BALTIMORE</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 8 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Faulkner</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u> ADDRESS	

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
				HARVEY, EMMETTE EMMITT				Aug. 7 '68 8:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD								4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)								C. CITY OR TOWN D. INSIDE CITY LIMITS?			
36 FRANKLIN SQUARE Bldg.								MARYLAND BALTIMORE YES <input type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER								1532 W. FAYETTE STREET			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
M		N				10/3/12		55			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
PILE DRIVER				GEN Contractor				GEORGIA		U. S. A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
Richard Harvey				Sally Williams							
15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO				206184013		ANNE SMITH 1259 FINLEY AVE.					
18. CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH											
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)											
ANTCEDENT CAUSES											
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
491X II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0								20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Aug. 7 1968 to Aug. 7 1968, that (I) (we) last saw the deceased alive on Aug. 7 8:00 PM 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE								23B. DATE SIGNED			
Chaul Da Kwon M.D.								8/7/68			
23C. PHYSICIAN'S NAME (Type)								23D. ADDRESS			
Chaul Da Kwon M.D.								FRANKLIN SQUARE Bldg.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial 8/10/68				8/10/68		Toccoa Ga		Toccoa Ga			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS			
AUG 9 1968				Robert E. Fairbank				Marshall P. Hays 638 N. Gilman St			

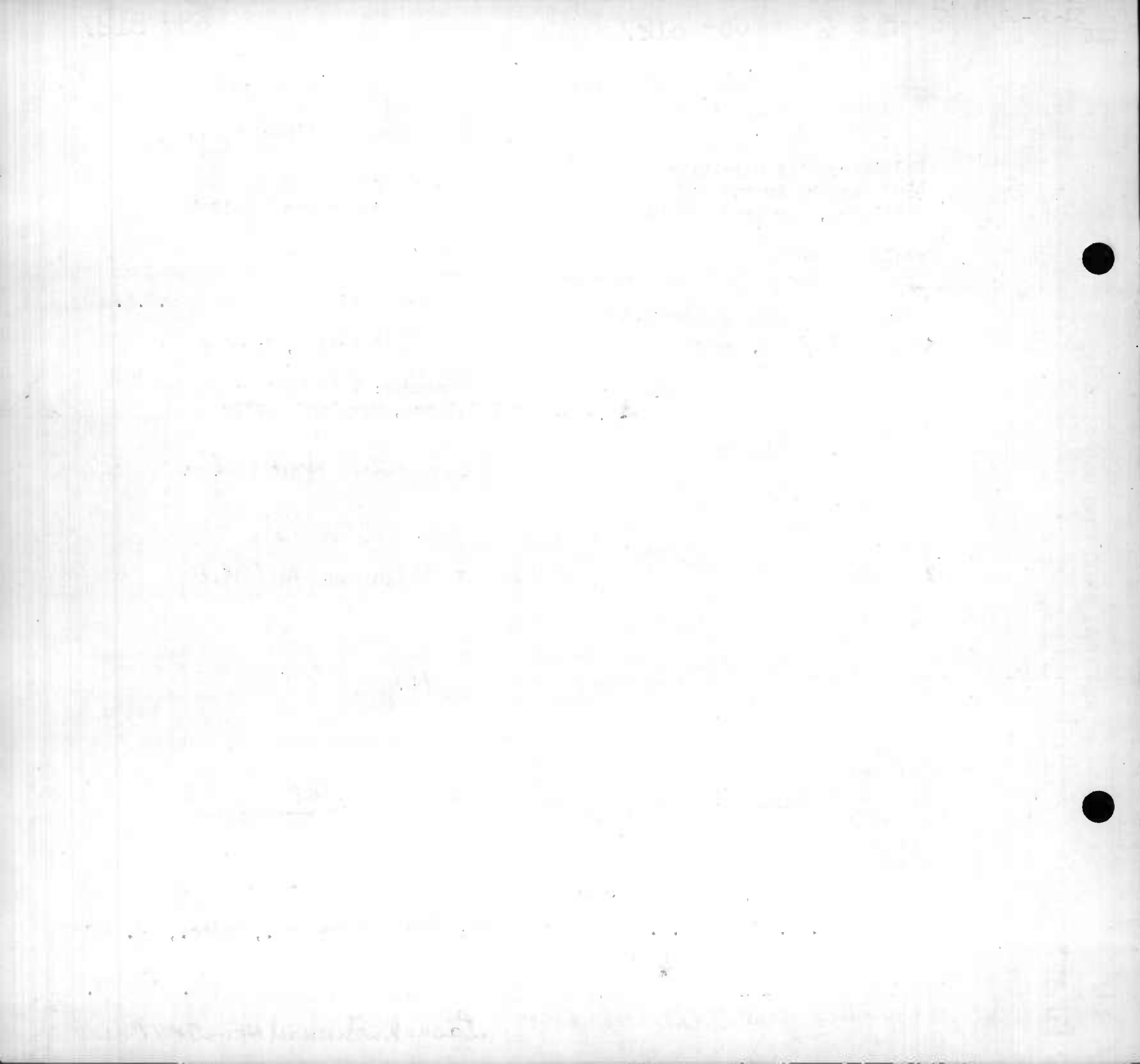
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*Prothymus*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JANET STONER		8 <sup>30</sup> AM 8/6/68 1 8 <sup>30</sup> A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224				Maryland Baltimore 53-00	
				C. CITY OR TOWN D. INSIDE CITY LIMITS	
				Baltimore YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER	
				3320 Summit Avenue #21234	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8/16/27		40
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Housewife		Maryland Baltimore	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Claude E. Duffy			Carling, Dorothy		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		111-22-8537		BCH Records: 4940 Eastern Avenue Baltimore, Maryland #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the made of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				3 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				1 week	
(B) DUE TO, OR AS A CONSEQUENCE OF:				10 years	
(C) Malignant Melanoma, Metastatic					
190.9 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8-2 19 68 to 8-6 19 68, that (I) (we) last saw the deceased alive on 8-6 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
J. V. RUSSO, M.D.				8-6-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
J. V. RUSSO, M.D.				BCH: 4940 Eastern Ave., Balto., Md. #21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8-9-1968		Gardens of Faith Cemetery Baltimore Co. Md.	
25A. DATE RECD BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 9 1968		Robert E. Fairbanks		Lassahn Funeral Home 7401 Belair Road	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 8128

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Reba Galler</u>		2. DATE AND HOUR OF DEATH <u>7/8/68</u>   <u>12<sup>45</sup></u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>9-02</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital of Baltimore</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>4100 Loch Raven Blvd</u>					
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/28/19</u>	9. AGE (In years lost birthday) <u>68</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Jahor-Abu Tabak</u>		14. MOTHER'S MAIDEN NAME <u>Baala TABAK</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-52-6013</u>		17. INFORMANT <u>Mrs. Audrey Miller</u> ADDRESS <u>3203 Stratford Ave.</u>	
18. <u>250.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebrovascular Accident</u> (B) <u>Cerebral Arteriosclerosis</u> (C) <u>Diabetes &amp; Hypertension</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>10 years</u> <u>15+ years</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>260X II</u>		<u>Infect. Decubitus ulcers</u>		<u>1 week</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>5/30</u> 19 <u>68</u> to <u>7/8</u> 19 <u>68</u> , that (1) (we) last saw the deceased alive on <u>7/7</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stanford H. Malinow MD</u>		23B. DATE SIGNED <u>7/8/68</u>		23C. PHYSICIAN'S NAME (Type) <u>Stanford H. Malinow MD</u>	
23D. ADDRESS <u>Sinai Hospital of Baltimore</u>		23E. DEGREE <u>MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-8-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>United Hebrew Cme</u>	
24D. LOCATION <u>Washington Bldg Baltimore Md</u>		24E. CITY, TOWN, OR COUNTY <u>Baltimore Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 9 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR <u>Jack Lewis Inc. 2100 Euston Pl</u>	

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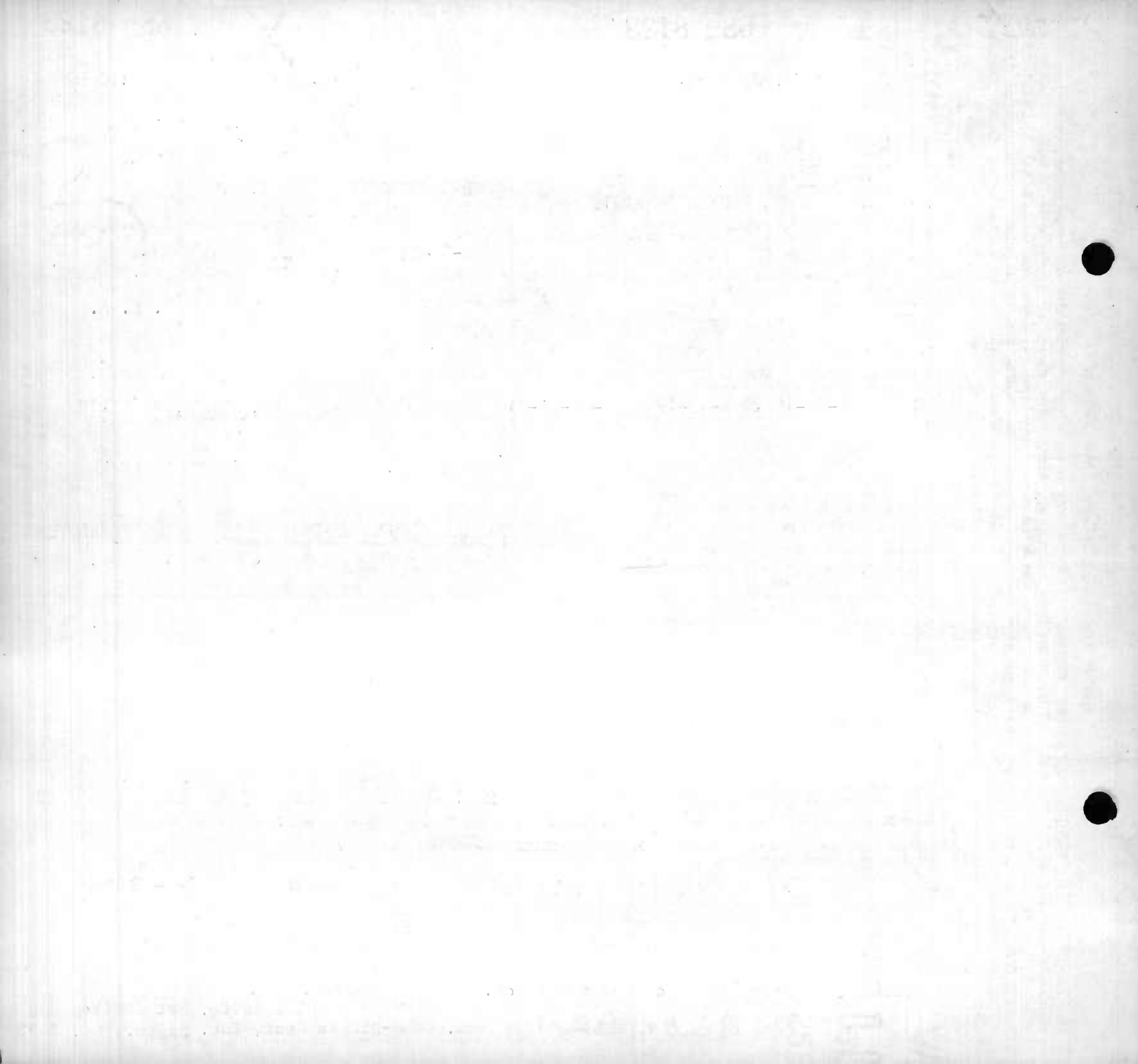
215-22-413 from under the 33rd

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 2em;">X</span>	68- 8129
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>DALFONZO, John MMI</b>			2. DATE AND HOUR OF DEATH <b>5 AUGUST 1968</b>		<b>2:10 P</b> M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b> <b>23 3900 LOCH RAVEN BOULEVARD</b> <b>BALTIMORE, MARYLAND 21218</b>			C. CITY OR TOWN <b>CATTONSVILLE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER <b>332 GREENLAW ROAD</b>		
5. SEX <b>MALE</b>	6. RACE <b>CAUCASION</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-10-<del>25</del> 94</b>	9. AGE (In years last birthday) <b>73 74</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FRUIT DEALER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>FOOD</b>	11. BIRTHPLACE (State or foreign country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>SAMUEL DALFONZO</b>			14. MOTHER'S MAIDEN NAME <b>ANITA BATALIA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 4-26-18 TO 4-15-19</b>			16. SOCIAL SECURITY NO. <b>219-07-34-11</b>		17. INFORMANT <b>HOSPITAL RECORDS</b> ADDRESS <b>3900 LOCH RAVEN BLVD, BALTO, MD 21218</b>
18. <b>433.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(A) IMMEDIATE CAUSE <b>CEREBRAL ARTERY THROMBOSIS</b> DUE TO, OR AS A CONSEQUENCE OF:			<b>48 HOURS</b>		
(B) <b>CEREBRAL ARTERIOSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF:			<b>SEVERAL YEARS</b>		
(C) _____					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>332 X II</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>5 1 AUGUST</b> 19 <b>68</b> to <b>5 AUGUST</b> 19 <b>68</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>5 AUGUST</b> 19 <b>68</b> and that in <b>(X)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(X)</b> (We) (did) <b>(X)</b> (not) view the body after death.					
23A. SIGNATURE <b>Susan H. Mather MS</b>				23B. DATE SIGNED <b>8-5-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>SUSAN HOWARD MATHER MD</b>			23D. ADDRESS <b>3900 LOCH RAVEN BLVD</b> <b>BALTIMORE, MARYLAND 21218</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8-8-1968</b>	24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>6212 Balto. Nat'l Pike</b> <b>Wm. Cook-Brooks West, Inc. Balto., Md. 21229</b>	



FUNERAL DIRECTOR: IMPORTANT


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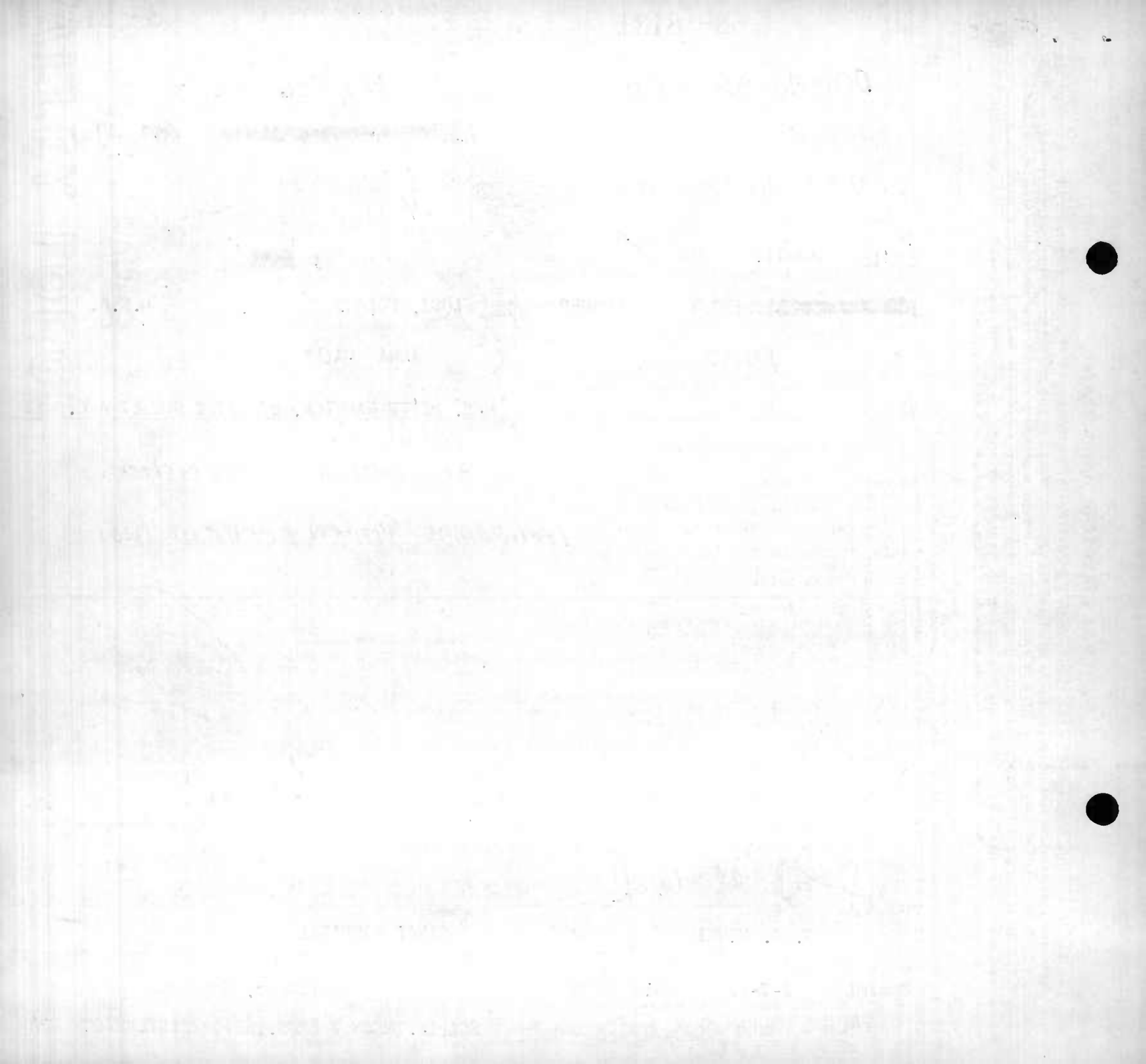
BIRTH NO.		BALTIMORE CITY HEALTH DEPT.		REG. NO.
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
HARRY V. GRAF		8-7-68 6:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE B. COUNTY		
34 Bon Secours Hospital		Maryland Baltimore 53-00		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN D. INSIDE CITY LIMITS?		
		BALTIMORE 21236 YES <input type="checkbox"/> NO <input type="checkbox"/>		
5. SEX		6. RACE		
M		W		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2-27-1896		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday)		
Pattern maker		72		
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
Glen L. Martin Co.		Maryland		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
FREDERICK GRAF		Ms Collough		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		
No		215-03-70724		
17. INFORMANT		ADDRESS		
Pt's Chart				
18. 553.0 I		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		EVA ?		
DUE TO, OR AS A CONSEQUENCE OF:		7 days		
ANTECEDENT CAUSES		(B) Fluid & Electrolyte Imbalance		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:		
10 days		(C)		
561.1 II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
7-26-68		Strangulated Rt. Femoral Hernia		
20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
No				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.)		
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from 7-26 1968 to 8-7 1968, that (I) (we) last saw the deceased alive on 8-7 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
Vallop		8-7-68		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
VALLOP BOONPRAKONG		Bon Secours Hospital 2025 W. Fayette St.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		
Burial		8-10-1968		
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		
Gardens of Faith Cemetery		Baltimore Co. Md.		
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		
AUG 9 1968		Robert E. Farkner		
25C. FUNERAL DIRECTOR		ADDRESS		
Lassahn Funeral Home		7401 Belair Rd.		



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">68- 8131</span>
68- 8131				CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>DAN M. HARWICK</b>		
2. DATE AND HOUR OF DEATH <b>8/8/68-12:40 PM</b>		M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>1324 DORCHESTER</b>				
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>63</b>	9. AGE (In years last birthday) <b>63</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHEMIST</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RUBBER</b>		11. BIRTHPLACE (State or foreign country) <b>LODZ, POLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>HARWICK</b>		14. MOTHER'S MAIDEN NAME <b>ANNA MALUP</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. BETTY HARWICK, c/o 5902 SUNSET AVE. #7</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>423X1</b> (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH <b>CARDIO - RESPIRATORY INSUFFICIENCY</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>PERICARDIAL PLEURAL EFFUSION POSSI</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
19A. DATE OF OPERATION <b>434.3 II</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>8/6</b> 19 <b>68</b> to <b>8/6</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE 		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>G. A. MINKIN</b>
23D. ADDRESS <b>SINAI HOSPITAL</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>8-7-68</b>	24C. NAME of CEMETERY or CREMATORY <b>OHEB SHALOM</b>	24D. LOCATION (City, town, or county) <b>BALTIMORE, Maryland</b>	(State)
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 9 1968</b>	25B. NAME OF REGISTRAR <b>Robert E. Farber</b>	25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>		



FUNERAL DIRECTOR: IMPORTANT

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68- 8132

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 8132

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Cora Rose Holt</i>		2. DATE AND HOUR OF DEATH <i>August 6, 1968.</i> <i>8 A.</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>11-01</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>903 North Calvert St.</i>		C. CITY OR TOWN <i>Baltimore</i>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>903 North Calvert St.</i>	
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/17/1891</i>	9. AGE (In years lost birthday) <i>76</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Landlady</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Frank Dixon</i>		14. MOTHER'S MAIDEN NAME <i>Sally Ann Tilghman</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT (Sister) <i>903 N. Calvert Street</i> <i>Mrs. Florence Dixon, Baltimore, Maryland</i>	
18. <i>410.9 + 1250.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Coronary Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Sudden</i> (B) <i>Arterio-Sclerotic Cardio-Vascular</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Disease</i> (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>420.1 II</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2-4</i>		
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8/5</i> <i>1968</i> to <i>8/6</i> <i>1968</i> , that (I) (we) last saw the deceased alive on <i>8/5</i> <i>1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Joseph S. Blum</i>				23B. DATE SIGNED <i>8/6/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>JOSEPH S. BLUM MD</i>				23D. ADDRESS <i>1115 N. CALVERT ST.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/8/68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Parsons Cemetery</i>	
24D. LOCATION <i>Salisbury, Wicomico, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 9 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Holloway &amp; Co. Salisbury, Md.</i>			

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# 68- 8133 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 8133

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Katherine Danenman</b>		2. DATE AND HOUR OF DEATH <b>6 August 1968</b> <b>10:00a.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Fayette Convalescent Home</b> <b>1105 East Fayette Street</b>		E. STREET AND NUMBER <b>5437 Springlake Way</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/6/72</b>	9. AGE (In years last birthday) <b>96</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>George Grabner</b>		14. MOTHER'S MAIDEN NAME <b>Magdalene Treggser</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-52-2907-J1</b>		17. INFORMANT <b>Betty Elgin</b> ADDRESS <b>5437 Springlake Way</b>	
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>CVA</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>Sev. Yrs.</b>		19. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Conjunctive Heart Failure</b> 19C. AUTOPSY? (Yes or No) <b>no</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
20A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>Jan. 23</b> 19 <b>67</b> to <b>Aug 6</b> 19 <b>68</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Aug 6</b> , 19 <b>68</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(do not)</del> view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED <b>8-6-68</b>		23C. PHYSICIAN'S NAME (Type) <b>E. Ellsworth Cook, M.D.</b>	
23D. ADDRESS <b>2431 Md. Ave.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-8-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Carmel</b>		24D. LOCATION (City, town, or county) <b>Balto.</b>		24E. (State) <b>Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>Helma A. Hoffmann</b> ADDRESS <b>3218 Hudson St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68- 8134</b>	
<div style="display: flex; justify-content: space-between;"> <span><b>BIRTH NO.</b> <u>68- 8134</u></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
<b>1. NAME OF DECEASED</b> (Type or Print) <u>LEVIN, TILLIE</u>			<b>2. DATE AND HOUR OF DEATH</b> <u>8/7/68</u> <u>12:00 Noon</u>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 The Johns Hopkins Hospital</u>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS <u>YES</u> E. STREET AND NUMBER <u>3901 Ford Rd.</u>		
<b>5. SEX</b> <u>Female</u>	<b>6. RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>- -1890</u>	<b>9. AGE</b> (In years last birthday) <u>77</u>	<b>10. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>La</u>	
<b>13. FATHER'S NAME</b> <u>Joseph</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Lena</u>		
<b>15. Was Deceased ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT</b> <u>Mrs Edith Pomerantz</u>		
			<b>ADDRESS</b> <u>Circle 8207 Maple</u>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the underlying condition last.			<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Uremia</u> (B) <u>Multiple myeloma</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <u>72 hrs.</u> <u>6 mos.</u>
<b>203X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Diabetes mellitus</u>					
<b>19A. DATE OF OPERATION</b> <u>8</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <u>Yes</u>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>Aug. 4, 1968</u> <b>to</b> <u>Aug. 7, 1968</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Aug. 7, 1968</u> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>Leonard Rosoff, Jr., M.D.</u>				<b>23B. DATE SIGNED</b> <u>8-7-68</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>Leonard Rosoff, Jr., M.D.</u>				<b>23D. ADDRESS</b> <u>601 N. Broadway</u>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>24B. DATE</b> <u>8/8/68</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>Hebrew Friendship</u>	
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Balta Md</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>AUG 9 1968</u>			
<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Fairburn</u>		<b>25C. FUNERAL DIRECTOR</b> <u>Sylvan S. Lewis &amp; Son, Inc</u>			
		<b>ADDRESS</b> <u>9610 Rustentown Rd</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital (and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8135	
BIRTH NO. 65		68- 8135		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) OTTO R. STERNFELD			2. DATE AND HOUR OF DEATH 8-7-68 4:25 PM M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL			A. STATE MARYLAND B. COUNTY 25-41		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE,		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 5601 ELDERON AVE		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-27-85	9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME BERNARD		14. MOTHER'S MAIDEN NAME LENA		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-09-3054		17. INFORMANT Mrs Florence Stone 8214 Bellona Lane	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL ISCHEMIA			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-5 MINUTES		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RESPIRATORY FAILURE 10 days		
			(B) DUE TO, OR AS A CONSEQUENCE OF: CHRONIC OBSTRUCTIVE PULMONARY EMPHYSEMA		
			(C) Gastrointestinal bleeding, duodenal ulcer		
MEDICAL CERTIFICATION					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 527.1 II					
19A. DATE OF OPERATION 7/28/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GI Bleeding		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/1 19 68 to 8/7 19 68, that (I) (we) last saw the deceased alive on 8/7 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE James K. Condon, M.D.				23B. DATE SIGNED 8/7/68	
23C. PHYSICIAN'S NAME (Type) JAMES K. CONDON, M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/9/68		24C. NAME OF CEMETERY or CREMATORY B'nai Israel	
				24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Sylvan S. Lewis & Son, INC 9610 Reservoir Rd	

RECEIVED 11-10-58

MYOCARDIAL ISCHEMIA  
RESPIRATORY FAILURE  
CHRONIC OBSTRUCTIVE PULMONARY DISEASE  
Gastrointestinal disorder, chronic

at present no

4/2/58

8/1

8/1

8/1

8/1

James K. Gander, MD

4/2/58 ✓

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8136

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CECILE M. HERRMAN</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>August 5, 1968</b> 10:40 P.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>405 Long Island Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 5, 1968 10:40 P.M.</b>	
6. SEX <b>female</b> 7. RACE <b>white</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>25-31</b>	
9. DATE OF BIRTH <b>11/20/1898</b> 10. AGE (In years last birthday) <b>68</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) <b>CRISTFIELD-MD</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.-A</b>		E. STREET AND NUMBER <b>405 Long Island Avenue</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b> 14B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME <b>ALBEE MOORE</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		15. MOTHER'S MAIDEN NAME <b>REBECCA ALBERT</b>	
17. SOCIAL SECURITY NO. <b>24-22864</b>		18. INFORMANT <b>EDWARD J. HERRMAN</b> ADDRESS <b>405 LONG ISLAND</b>	
19. <b>412.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive Cardiovascular Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>443X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
20A. DATE OF OPERATION <b>0</b> 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>8/6/68</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>AUG-8-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>CRISTFIELD-MD</b>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>	
25C. FUNERAL DIRECTOR <b>F.B. WIPPERT-1300 BUTAN-PEACE</b>		ADDRESS	

WALTER B. BROWN

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8137

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

PERCY JOHNSON

2. DATE  
OF  
DEATHKnown ☒  
Estimated ☐

Month

Day

Year

Hour

8

7

68

1:39 a M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

August 7, 1968

1:39 a M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

7. RACE

8. MARRIED ☒NEVER MARRIED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Male

Colored

WIDOWED ☐DIVORCED ☐

Balto.

YES ☒NO ☐

9. DATE OF BIRTH

10. AGE (In years  
lost birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

May 17, 1910

58

2803 Baker St.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF

WHAT COUNTRY?

13. FATHER'S NAME

James City Co., Va.

U.S.A.

WILLIE W. JOHNSON

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Laborer

HATTIE JOHNSON

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

No.

(If yes, give war or dates of service)

228-05-7088

Mrs. Irene Johnson 2803 Baker Street

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Pulmonary carcinoma (right lung)  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

163X II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

0

No

22A. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 7, 1968

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

8-11-68

Chicahomie Ch. Cem.

Toano,

Virginia

25A. DATE RECEIVED BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

AUG 9 1968

Robert E. Fisher, M.D.

MORTON &amp; DYETT F.H. 1701 Laurens St

VALLEY

VALLEY

VALLEY

1  
S-530

68- 8138 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8138

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>HANNAH SNEED</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> <b>August 7, 1968</b>		Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 927 N. Calhoun Street</b>		3. DATE PRONOUNCED DEAD <b>August 7, 1968</b>		Month Day Year Hour <b>3:25 P. M.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH <b>12-24-1904</b>		10. AGE (In years lost birthday) <b>63</b>		11. BIRTHPLACE (State or foreign country) <b>N. Thumberland Co., Va. U.S.A.</b>	
12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>GLASCOE SMITH</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory Worker</b>	
15. MOTHER'S MAIDEN NAME <b>TOPSY SMITH</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		17. SOCIAL SECURITY NO. <b>215-16-1784</b>	
18. INFORMANT <b>Mrs. Mary Savage</b>		19. ADDRESS <b>927 N. Calhoun St.</b>		20. CAUSE OF DEATH <b>Carcinoma of sigmoid colon with metastases</b>	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</b>		22. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>metastases</b>		23. (B) DUE TO, OR AS A CONSEQUENCE OF: <b>(C)</b>	
24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>153.8 II</b>		25. DATE OF OPERATION <b>6</b>		26. CONDITION FOR WHICH OPERATION WAS PERFORMED	
27. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
30. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>August 8, 1968</b>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-12-68</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		25D. ADDRESS <b>1701 Laurens St.</b>			

272800

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68- 8139	
BIRTH NO. 6				BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) <i>Lelia H. Porter</i>			2. DATE AND HOUR OF DEATH <i>Aug 5 1968</i> <i>6A</i> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 The Wesley Home</i> <i>2211 W Rogers Ave</i>			A. STATE <i>Maryland</i> B. COUNTY <i>27-15</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>2211 W Rogers Ave</i>		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 7 1891</i>	9. AGE (In years last birthday) <i>76</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State of foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John H Harrison</i>			14. MOTHER'S MAIDEN NAME <i>Mary E Smith</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>2161869004</i>		17. INFORMANT <i>Wesley Home Records</i>
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>(A) Myocardial infarction</i> <i>(B) Arterio-sclerotic cardio-vascular disease</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>420.1 II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9 October 1967</i> to <i>5 August 1968</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>30 July 1968</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We)</i> <i>(did)</i> <i>(did not)</i> view the body after death.					
23A. SIGNATURE <i>John N Barnaby</i> DEGREE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>John N Barnaby</i> DEGREE				23D. ADDRESS <i>1652 E Belvedere Ave</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>8 Aug 68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Spring Hill Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Easton Maryland</i>		25A. DATE RECEIVED BY HEALTH DEPT. <i>AUG 5 1968</i>			
25B. NAME OF REGISTRAR <i>John E. Barber</i>		25C. FUNERAL DIRECTOR <i>Burger Funeral Home B. H. My</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 68- 8140 CERTIFICATE OF DEATH

REG. NO. **68- 8140**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Walter A Pearce</b>		2. DATE AND HOUR OF DEATH <b>8-6-68 9:40 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>13-07</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Bottom Hill Nursing &amp; Convalescent Center</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>90</b>			F. STREET AND NUMBER <b>917 W. 38th Street</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-2-86</b>	9. AGE (In years lost birthday) <b>82</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Walter Pearce</b>			14. MOTHER'S MAIDEN NAME <b>Parah Barnes</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-12-9288</b>		17. INFORMANT ADDRESS <b>James Pearce 4125 Beaunavista Ave</b>	
18. <b>342X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Parkinson's Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>several yrs.</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		
19. DATE OF OPERATION <b>350X II</b>			20. AUTOPSY? (Yes or No) <b>no</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.)		
21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?		
22. I certify that <u>(U)</u> (this hospital) attended the deceased from <b>7-11</b> <b>19 68</b> to <b>8-6</b> <b>19 68</b> , that <u>(U)</u> (we) lost saw the deceased olive on <b>8-4</b> <b>19 68</b> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>(U)</u> (We) (did) (did nat) view the body after death.			23B. DATE SIGNED <b>8-7-68</b>		
23A. SIGNATURE <b>E. Elsworth Cook</b>			23C. PHYSICIAN'S NAME (Type) <b>E. ELISWORTH COOK M.D.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>8-9-68</b>		
24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Pikesville Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 9 1968</b>			25B. NAME OF REGISTRAR <b>Robert E. Jankins</b>		
25C. FUNERAL DIRECTOR <b>BURGEE FUNERAL HOME, BALTI Md</b>			25D. ADDRESS <b>By William R. Kleiber</b>		

W. H. H. H.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 8141

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Lester Clark</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>August</b> Day <b>7</b> Year <b>1968</b> Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2518 Oliver Street</b>		3. DATE PRONOUNCED DEAD Month <b>August</b> Day <b>7</b> Year <b>1968</b> Hour <b>10:30 P.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
9. DATE OF BIRTH <b>8/19/38</b>		10. AGE (In years last birthday) <b>30</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>N.C.</b>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME <b>Annie Dawson</b>		18. INFORMANT ADDRESS <b>Mrs. Susie Wright 2518 E. Oliver St.</b>	
19. <b>343.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cerebral palsy</b> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
352X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>August 8, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/10/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE RECEIVED BY HEALTH DEPARTMENT <b>AUG 10 1968</b>		25B. NAME OF REGISTRAR <b>Wm C March</b>	
25C. FUNERAL DIRECTOR <b>928 E. North Ave.</b>		ADDRESS	

Charles E. Light

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8142

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 8142

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>James Barnes</b>		2. DATE AND HOUR OF DEATH <b>8-8-68</b> <b>1:45 a.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>39 Provident Hospital, Inc. 1514 Division St. Baltimore, Maryland 21217</b>			C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1161 Whatcoat St.</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-13-81</b>	9. AGE (In years last birthday) <b>87</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Luther Barnes</b>			14. MOTHER'S MAIDEN NAME <b>Amanda Barnes</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. James Barnes, Jr. (Son)</b>	
				ADDRESS <b>Same</b>	
18. <b>427.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CVA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Atrial Fibrillation</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>433.1 II</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
19C. DATE OF OPERATION			20A. AUTOPSY? (Yes or No) <b>No</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
22. I certify that (I) (this hospital) attended the deceased from <b>Aug. 3, 1968</b> 19 to <b>Aug. 8, 1968</b> 19 that (I) (we) last saw the deceased alive on <b>Aug. 8, 1968</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>A. Khaliq</b>			23B. DATE SIGNED <b>8-8-68</b>		
23C. PHYSICIAN'S NAME (Type) <b>A. Khaliq</b>			23D. ADDRESS <b>1514 Division St.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/12/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cem</b>	
24D. LOCATION <b>Balto., Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>AUG 9 1968</b>		24F. NAME OF REGISTRAR <b>Robert E. Johnson</b>	
24G. DATE REC'D BY HEALTH DEPT.		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR <b>Wm C March</b>	
				ADDRESS <b>928 E. North Ave.</b>	

A. H. H. A

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 8143 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 8143

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Robert Watson Linn

2. DATE AND HOUR OF DEATH

Aug. 6, 1968

11:34

A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

US Public Health Service Hospital  
3100 Wyman Park Drive

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

W. Va.

C. CITY OR TOWN  
Fort Ashby

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

6/25/07

9. AGE (In years last birthday)

61

If Under 1 Yr. Months: Days

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Operator

10B. KIND OF BUSINESS OR INDUSTRY

Water Plant

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

George W. Linn

14. MOTHER'S MAIDEN NAME

Cora L. Smith

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

705-05-5339

17. INFORMANT

ADDRESS

Records- US PHS Hospital, Balto, Md.

18. 200.0 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

Reticulum cell sarcoma

15 mos.

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

200.0 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from Mar. 17 1968 to Aug. 6 1968, that (1) (we) last saw the deceased alive on Aug. 6 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Walter F. Oster, M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

8/6/68

23C. PHYSICIAN'S NAME (Type)

Walter F. Oster, Surgeon (R)

23D. ADDRESS

US PHS Hospital, Balto, Md. 21211

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-9-1968

24C. NAME OF CEMETERY or CREMATORY

Fort Ashby Cemetery

24D. LOCATION

(City, town, or county)

(State)

Fort Ashby, W. Va. Mineral

25A. DATE REC'D BY HEALTH DEPT.

AUG 9 1968

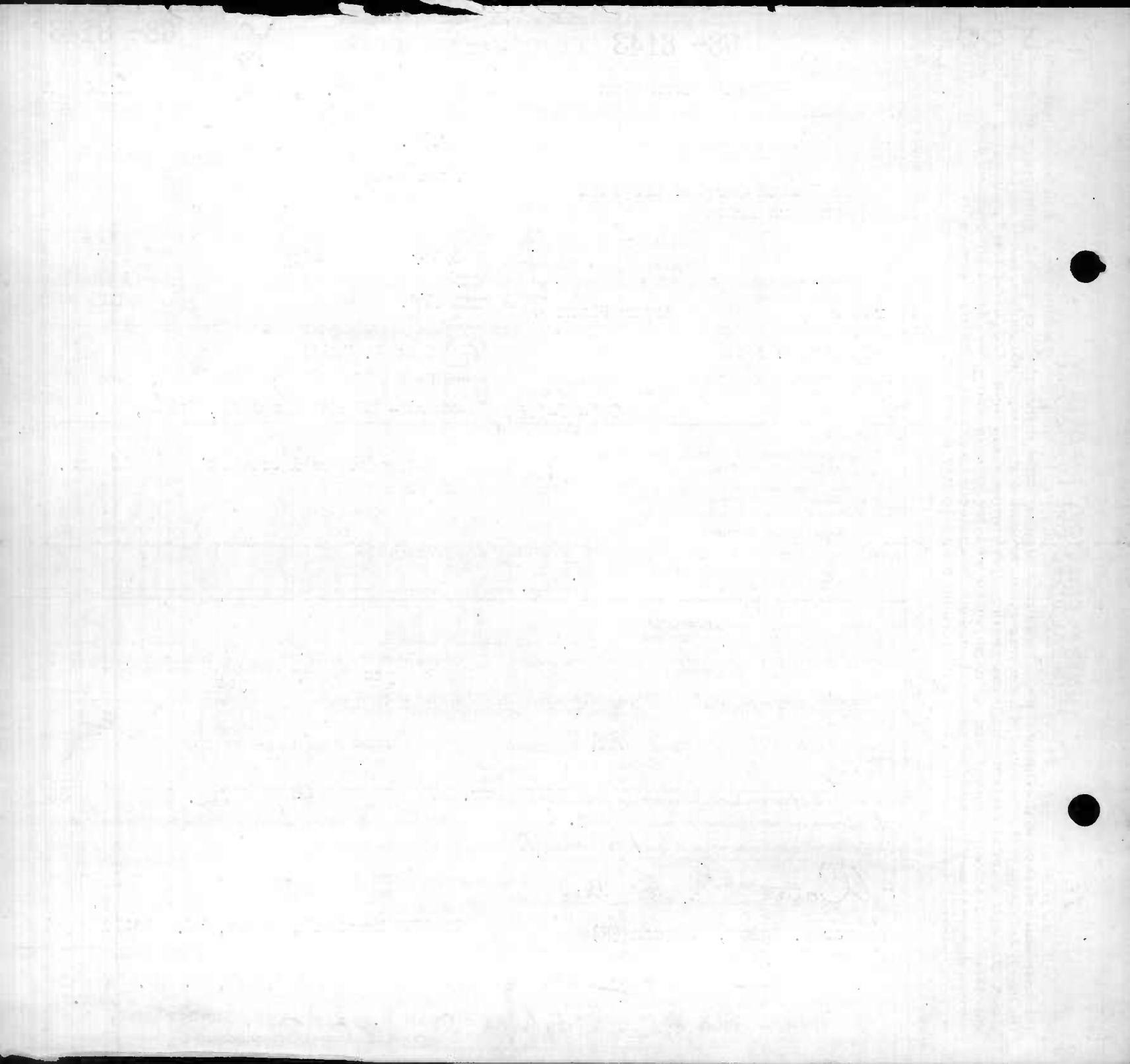
25B. NAME OF REGISTRAR

Robert E. Fisher

25C. FUNERAL DIRECTOR

James F. Scarpelli, Cumberland, Md.

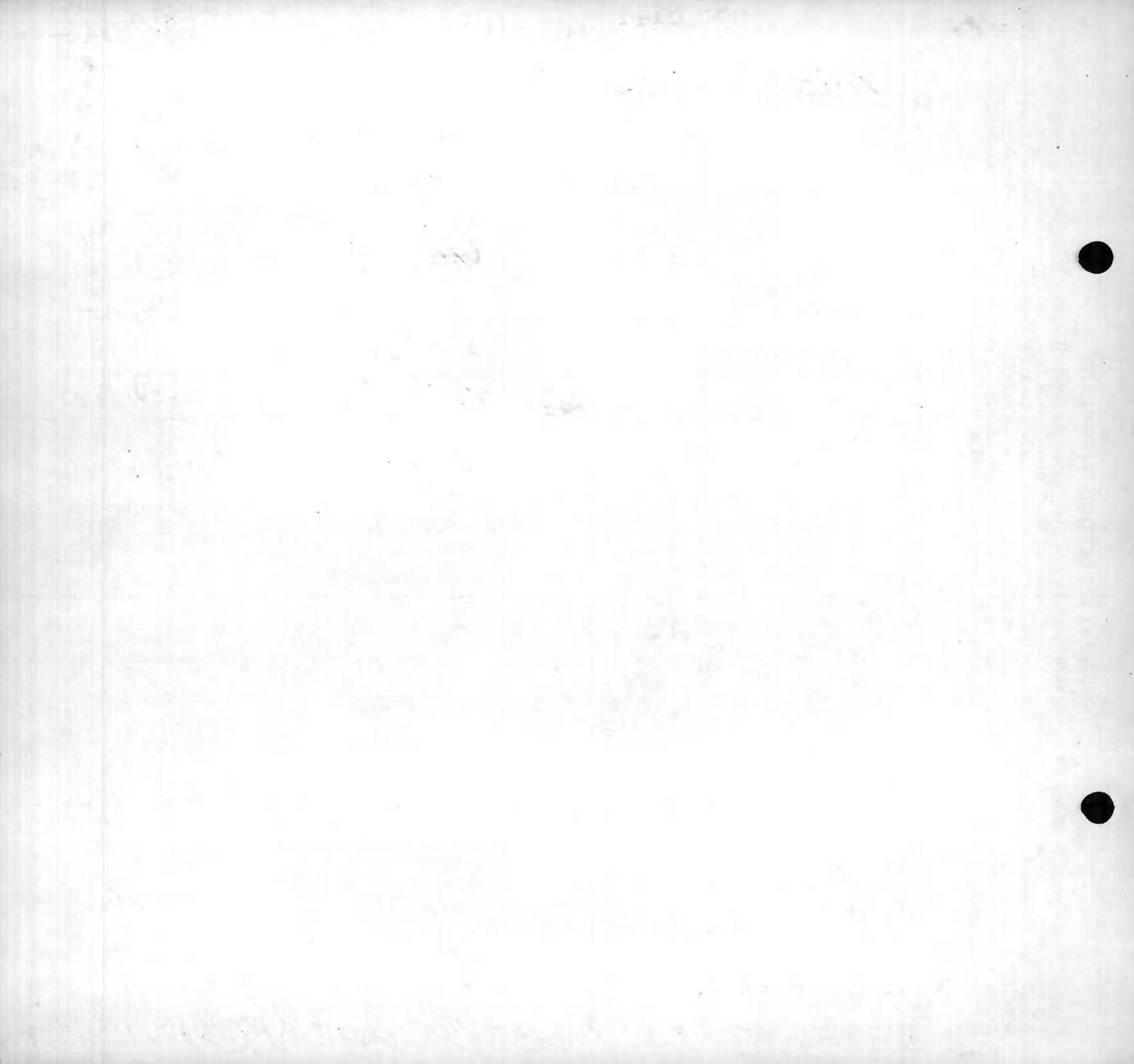
ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8144 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8144	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mittie Boykin</i>		2. DATE AND HOUR OF DEATH <i>8-8-68</i> <i>1:30 pm</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>5-01</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>7</i>		6. RACE <i>7</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>UNEMPLOYED</i>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>6/15/84</i> 9. AGE (In years last birthday) <i>84</i>	
11. BIRTHPLACE (State or foreign country) <i>NORTH Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>UNKNOWN</i>		14. MOTHER'S MAIDEN NAME <i>ADELINE BOYKIN</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>UNK</i>		17. INFORMANT ADDRESS <i>Tillie Lincolny 1202 WALDO CT</i>	
18. <i>412.4</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Respiratory arrest</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic cardiovascular</i> <i>subdural hemorrhage disease</i> (C) <i>arteriosclerosis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>few minutes</i>	
19A. DATE OF OPERATION <i>428.1</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>II</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Unknown</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>Unknown</i>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>Unknown</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>Presumably accidentally fell</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>Aug 8 1968</i> to <i>Aug 8 1968</i> , that (I) (we) last saw the deceased alive on <i>Aug 8 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>P. V. Salud</i>		23B. DATE SIGNED <i>Aug 7, 1968</i>			
23C. PHYSICIAN'S NAME (Type) <i>PONCIANO V. SALUD M.D.</i>		23D. ADDRESS <i>MERCY HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL-TRANSIT</i>		24B. DATE <i>8/11/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Carter Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Garland, N.C.</i>		24E. STATE <i>N.C.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 9 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Faldut</i>		25C. FUNERAL DIRECTOR <i>Marshall H. Jones Jr.</i>	
25D. ADDRESS <i>1735 Harford</i>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

68- 8145

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 8145

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Daisy D. Joyner		Aug. 7 '68 2:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
46 Lutheran Hosp. of Maryland.				Maryland 15-09	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3925 Fairview Avenue	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
F		C		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
retired				7-11-1880	
				9. AGE (In years last birthday) 88	
				11. BIRTHPLACE (State or foreign country) Maryland	
				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Lazarus Barrett				Emiline M. N. Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
17. INFORMANT				ADDRESS	
James H. Joyner				349 Beaumont	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH	
412.4 + 1E887X				ASCVD	
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease injury or complication which caused death.)				IMMEDIATE CAUSE	
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Fracture of R. Hip 10 weeks	
422.1 II				Fracture of R. Hip 10 weeks	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Fracture of R. Hip 10 weeks	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0 No				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		Home		unknown? Fairview 3925	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
5-2-68		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		Fell in bedroom at home	
22. I certify that (I) (this hospital) attended the deceased from 6-24-1968 to Aug. 7 1968, that (I) (we) last saw the deceased alive on Aug-7 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
PARK				Aug. 7 '68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
PARK				Lutheran Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Removal		8-8-68		Sunset Memorial Park Farmville N.C.	
25A. DATE REC'D		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 9 1968		Robert E. Taylor		Adlington & Shultz 1727 N. Mount St.	

10  
Exposition Internationale

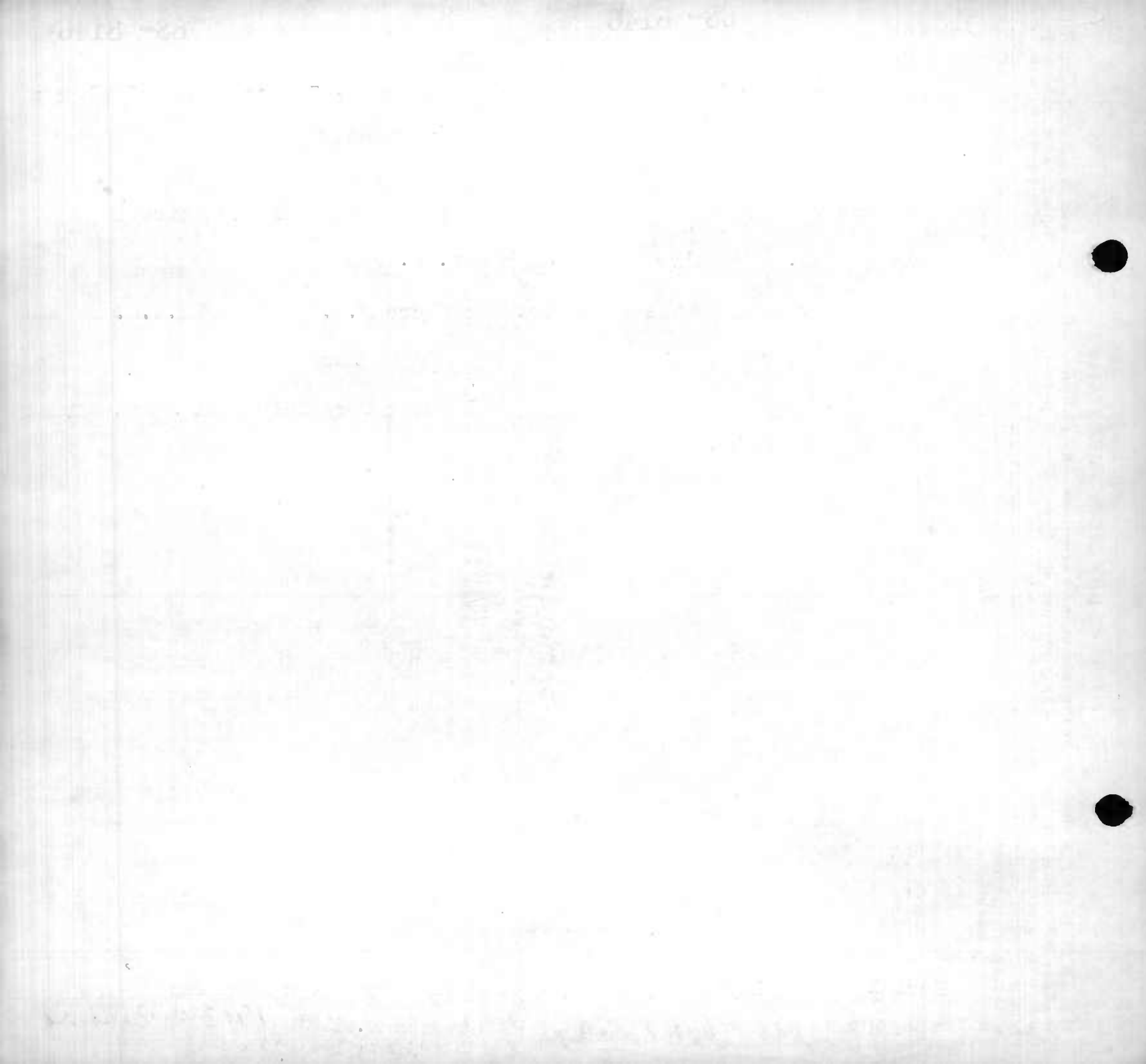
Paris 1889

— Exposition —  
Internationale

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68- 8146				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68- 8146	
1. NAME OF DECEASED (Type or Print) <b>Obie Core</b>				2. DATE AND HOUR OF DEATH <b>August-8th.1968</b>   <b>2-30-</b> <b>A M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Bon Secours Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1915 West Lexington Street</b>			
5. SEX <b>Male</b>	6. RACE <b>Col.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Nov.23.1902</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Paint Maker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Davis Paint Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Goldboro N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Louis Core</b>			14. MOTHER'S MAIDEN NAME <b>Dina More</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Almetter Core</b>		
			ADDRESS <b>1915 West Lexington St</b>				
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Coronary Occlusion</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>Several Hrs.</b>	
				(B) <b>Cardio Vascular Disease</b> DUE TO		<b>Unkown</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>420.1 II</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1-17-1967</b> to <b>8-8-1968</b> , that (I) (we) last saw the deceased alive on <b>6-19-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Richard H. Hunt</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>8/8/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Richard H. Hunt</b>				23D. ADDRESS <b>1607 W. Mulberry St Balto. Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/11/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Brooklyn Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Faldy</b>		25C. FUNERAL DIRECTOR <b>Stetson D. Wilson</b>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 8147

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ESTBAN URIVE</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>August 8, 1968</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>520 Richwood Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 8, 1968 2:45 A. M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Oct. 15, 1905</b>		10. AGE (In years last birthday) <b>62</b>	
11. BIRTHPLACE (State or foreign country) <b>SAN ANTONIO TEXAS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give dates of service) <b>YES</b>		17. SOCIAL SECURITY NO. <b>194-10-2870</b>	
18. INFORMANT <b>Helenetta Urive</b>		ADDRESS <b>520 Richwood Ave.</b>	
19. <b>011.9</b>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Tuberculosis pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) _____	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>8-13-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Bald Nat Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>	
25C. FUNERAL DIRECTOR <b>Clayton Wilson</b>		ADDRESS <b>1001 Brandy Ln</b>	

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 8148

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM RAY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>August 7, 1968</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 7, 1968 8:05 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Mercy Hospital (DOA)</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>17 N. Exeter Street</b>	
9. DATE OF BIRTH <b>1910</b>	10. AGE (In years last birthday) <b>58</b>	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO.		18. INFORMANT <b>Lusie Roy Samuels</b> ADDRESS	
19. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION <b>422.1 II</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>August 8, 1968</b>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8-12-68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary Cent</b>	24D. LOCATION (City, town, or county) (State) <b>A-A County Md</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 8 1968</b>		25B. NAME OF REGISTRAR <b>Rebecca E. Jones</b>		25C. FUNERAL DIRECTOR <b>Clayton Wilson Woodbury Inc</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

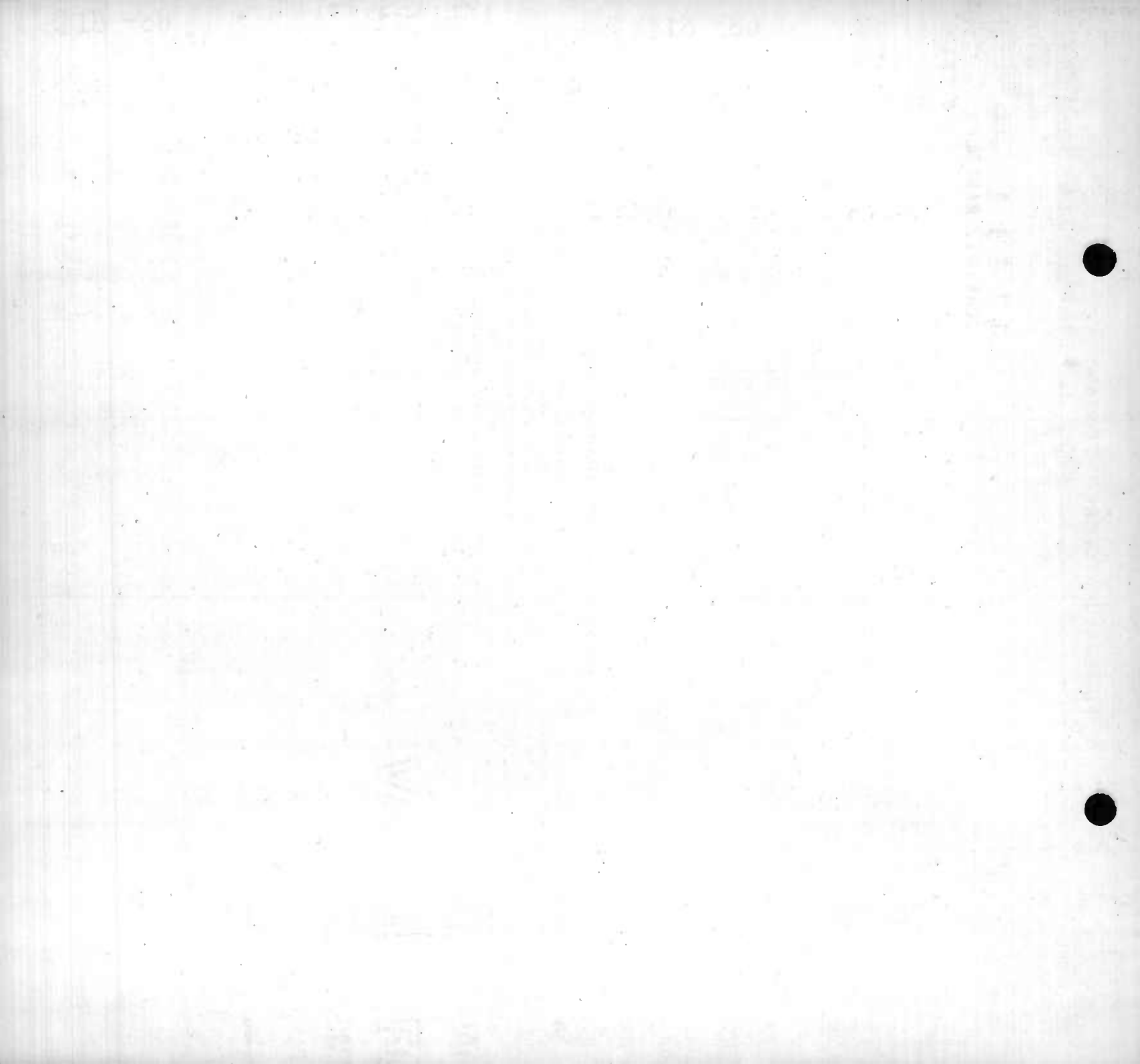
68- 8149

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

RANDOLPH  
REG. NO. 10-10-27

68- 8149

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JENKINS, Randolph		Aug. 7, 1968   6:30 a. m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
The Johns Hopkins Hospital		A. STATE B. COUNTY Maryland Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS	
33 The Johns Hopkins Hospital		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		1424 N. Chester St.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Male	Negroid	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	10-10-27	40	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Labor				Baltimore Va.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Jack C. Jenkins		Dorothy Henry		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
YES		214-24-5536		Dorothy Henry	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		10 years	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
581.0 II		Renal failure, Bleeding diathesis		3 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
3 8/5	Portal Hypertension	Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from 8/4 1968 to 8/7 1968, that (I) (we) last saw the deceased alive on 8/7 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Howard Snider MD		8/7/68			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
HOWARD SNIDER MD		550 NORTH BR. 601 N. BRIDWAY BALT. MD			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	8-12-68	Bethel Mt. Cent	Bethel Mt.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS		
AUG 9 1968	Robert E. Faldut	Elroy C. St. Jensen			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 8150 CERTIFICATE OF DEATH

REG. NO. 68- 8150

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Wicks, George E.</b>		2. DATE AND HOUR OF DEATH <b>7-8-68</b> <b>1 05</b> <b>A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
5. SEX <b>MALE</b>	6. RACE <b>COLORED</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/19/00</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Kind of work done during most of working life, if retired) <b>Government Employee</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md. USA</b>	
13. FATHER'S NAME <b>Richard B. Wicks</b>		14. MOTHER'S MAIDEN NAME <b>Annie Mosley</b>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>William Wicks, Son</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>204.2 II</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Bilateral Pneumonia</b>		<b>4 days</b>	
		(B) <b>Chronic Monocytic Leukemia</b>		<b>2 yrs.</b>	
		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>6/1/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>none</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from <b>January 1966</b> to <b>Aug 5 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 5 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>R. W. Light MD</b>				23B. DATE SIGNED <b>8/8/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Richard W. Light MD</b>		23D. ADDRESS <b>1504 McEldevy</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-13-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Crest</b>	
24D. LOCATION <b>Arbutus Crest</b>		(City, town, or county) (State)			
25A. DATE RECEIVED BY HEALTH DEPT. <b>8-13-68</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Shel Wilson</b>	
		ADDRESS <b>1000 Mount Airy Rd</b>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8151

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MELVIN SCOTT

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

8

6

68

8:08 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Johns Hopkins Hospital D.O.A.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

August

6

1968

8:08 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

Colored

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

1922

10. AGE (In years  
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1010 Aisquith St.

11. BIRTHPLACE (State or foreign country)

Safon Florida

12. CITIZEN OF  
WHAT COUNTRY?

SSA

13. FATHER'S NAME

Weldon Scott

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

15. MOTHER'S MAIDEN NAME

Olivia Scott

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war, dates of service)

YES

17. SOCIAL  
SECURITY NO.

253-16-4174

18. INFORMANT

Austin Scott

ADDRESS

Sun

19. E966X I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Stab wound of the chest  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

E982X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

in front of 1010 Aisquith St.

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

8

6

68

7:50p

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject stabbed on sidewalk

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 7, 1968

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8-13-68

24C. NAME of CEMETERY or CREMATORY

Mt Calvary Cmt

24D. LOCATION (City, town, or county) (State)

A &amp; W

25A. DATE REC'D BY HEALTH DEPT.

AUG 9 1968

25B. NAME OF REGISTRAR

Robert E. Jenkins

25C. FUNERAL DIRECTOR

Greg Wilson

ADDRESS

1010 Aisquith St

11-10-80

11-10-80

11-10-80

11-10-80

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11-10-80

11-10-80

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 68- 8152 CERTIFICATE OF DEATH

REG. NO. 68- 8152

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JERRY REID</b>		2. DATE AND HOUR OF DEATH <b>8/8/68 2:50 pm</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>The Johns Hopkins Hospital</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>1526 Ashland Ave</b>		
5. SEX <b>M</b>	6. RACE <b>N</b> <b>Negro Male</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 5 01</b>	9. AGE (In years lost birthday) <b>67</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Longshoreman</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Poultmouth Vt</b>	
13. FATHER'S NAME <b>John Reid</b>		14. MOTHER'S MAIDEN NAME <b>Pearl Ruffin</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>226 14 5823</b>		17. INFORMANT <b>Mary &amp; Reul Lane</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Embolus</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Pelvic Surgery</b> <b>Rectal Carcinoma</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b> <b>2 weeks</b> <b>? months</b>		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>15-4 X II</b>					
19A. DATE OF OPERATION <b>7/23/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Rectal Carcinoma</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7/20 1968</b> to <b>8/8 1968</b> , that (I) (we) lost saw the deceased alive on <b>8/8/68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Howard C Snider, Jr MD</b>				23B. DATE SIGNED <b>8/8/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>HOWARD C SNIDER, JR MD</b>				23D. ADDRESS <b>Johns Hopkins Hospital Baltimore Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-13-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cat Abitus</b>	
24D. LOCATION (City, town, or county) (State) <b>Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 9 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>E. L. Siga P. J. Kilian</b>		ADDRESS <b>2/85</b>	

February 1941

John G. ...  
Hester ...

1/20/41 ...

1/20/41 ...

Howard ...

Howard ...

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8153

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

OLEY

WILLIAMS

2. DATE  
OF  
DEATHKnown ☐ Estimated ☒

Month

Day

Year

Hour

August

6,

1968

10:00 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

August

6,

1968

11:55 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☒NO ☐

6. SEX

male

7. RACE

negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

1907

10. AGE (In years  
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

17 S. Dallas Street

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give year or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

19. 412.4

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME  
OF INJURY  
(APPROX.)22E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK ☐ AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/6/68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

WALSH & BROS.

WALSH & BROS.

WALSH & BROS.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

# 68- 8154 CERTIFICATE OF DEATH

REG. NO. 68- 8154

BIRTH NO. 50		1. NAME OF DECEASED (Type or Print) <i>Barbara G. Stamm</i>		2. DATE AND HOUR OF DEATH <i>7 August 1968 6:32 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> 8. COUNTY <i>Baltimore</i>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Church Home and Hospital</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <i>15 S. Potomac Street</i>			21224		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-10-90</i>	9. AGE (In years last birthday) <i>78</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House maker</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John A. Goertz</i>		14. MOTHER'S/MAIDEN NAME <i>Mathilda Diestch</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217 07 6025</i>		17. INFORMANT <i>Son</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral Vascular Accident</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Adenocarcinoma Sigmoid Colon</i>		
(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Diverticulosis with Peritoneal Abscess</i>			(C) _____		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>15-3-3 II</i>					
19A. DATE OF OPERATION <i>3 August 68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Adenocarcinoma</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3 August 1968</i> to <i>7 August 1968</i> , that (I) (we) lost saw the deceased alive on <i>7 August 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>James D. Bile's III M.D.</i>				23B. DATE SIGNED <i>7 August 68</i>	
23C. PHYSICIAN'S NAME (Type) <i>JAMES D. BILE'S III, M.D.</i>				23D. ADDRESS <i>CHURCH HOME - HOSPITAL BALTO. MD.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/10/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Oak Lawn Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE RECEIVED BY HEALTH DEPT. <i>AUG 9 1968</i>			
25B. NAME OF REGISTRAR <i>John E. Farkas</i>		25C. FUNERAL DIRECTOR <i>John A. Moran, Inc. 3000 E. Balto. St.</i>			

8/15

JAMES D. BAKER III, MD CHURCH HOME - HOSPITAL

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>68-8155</b>
68-8155		CERTIFICATE OF DEATH
BIRTH NO.		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
ZIPP, Anna M.		Aug. 8, 1968   10:40 a.m.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
FULL NAME OF HOSPITAL OR INSTITUTION  <b>33</b> The Johns Hopkins Hospital		A. STATE <b>Maryland</b>
		B. COUNTY <b>Baltimore</b>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b>
		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>2801 Bauernwood Ave.</b>
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY
		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>
13. FATHER'S NAME <b>Albert</b> <del>Augustus</del> Muller		14. MOTHER'S MAIDEN NAME <b>Caroline</b> <del>Carolyn</del> Stewe
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.
		17. INFORMANT <b>Margaret Zipp, 2803 Bauernwood Ave.</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  <b>15-3-31</b> <b>Intestinal Obstruction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Carcinoma of Sigmoid Colon</b> <b>11 years</b>
		(C) <b>Refractory Anaemia</b> <b>12 years</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
MEDICAL CERTIFICATION		
19A. DATE OF OPERATION <b>8/3/68</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intestinal Obstruction</b>	20A. AUTOPSY? (Yes or No) <b>Yes</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>July 29, 1968</b> to <b>August 8, 1968</b> , that (I) <del>for</del> last saw the deceased alive on <b>August 8, 1968</b> and that in (my) <del>my</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> (did not) view the body after death.		
23A. SIGNATURE <b>Alan C. Woods, Jr. M.D.</b>		23B. DATE SIGNED <b>August 8, 1968</b>
23C. PHYSICIAN'S NAME (Type) <b>Alan C. Woods, Jr., M.D.</b>		23D. ADDRESS <b>The Johns Hopkins Hospital</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8-12-68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Parkwood</b>
		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>
		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8156

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>THOMAS James JUBB</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>August 8, 1968</b>		Hour <b>12:35 P.M.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>31 CITY HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>August 8, 1968</b>		Hour <b>12:35 P.M.</b>
5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balts Co 53-00</b>				
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>July 10, 1932.</b>		10. AGE (In years last birthday) <b>36</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		E. STREET AND NUMBER <b>6018 Nahant Street</b>
13. FATHER'S NAME <b>Paul G. Jubb, Sr.</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer (Unemployed)</b>		
15. MOTHER'S MAIDEN NAME <b>Elizabeth P. Phillips</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes Korean</b>		
17. SOCIAL SECURITY NO. <b>218-28-1975</b>		18. INFORMANT ADDRESS <b>Mrs. Paul G. Jubb (Same)</b>		
19. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>422.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Pulmonary Emphysema</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>August 9, 1968</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/12/68.</b>		24C. NAME of CEMETERY or CREMATORY <b>Balto. National Cem.</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 9 1968</b>		
25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		

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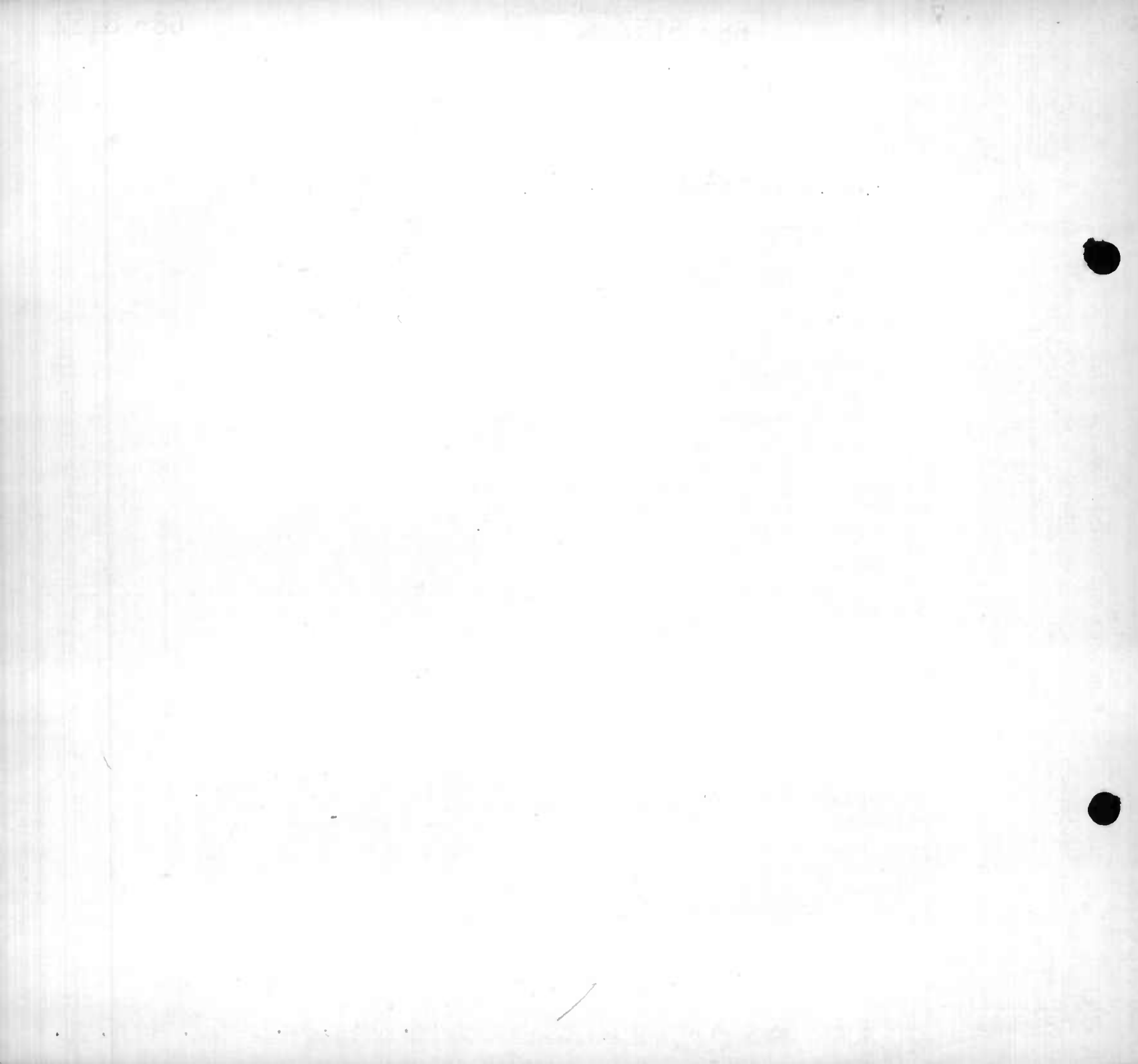
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 68- 8157 CERTIFICATE OF DEATH

REG. NO. 68- 8157

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>LYNCH, LOIS V.</b>		2. DATE AND HOUR OF DEATH <b>August 7, 1968 7:35 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <b>46 Lutheran Hospital of Maryland</b>				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3025 Windsor Avenue</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/17/'08</b>	9. AGE (In years last birthday) <b>59</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Norfolk, Virginia</b>	
13. FATHER'S NAME <b>Charlie Kendell Walker</b>				14. MOTHER'S MAIDEN NAME <b>Ethel Turner</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>From chart</b> ADDRESS <b>From chart.</b>	
18. <b>412.71</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>A.S.C.V.A.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>422.1 II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7/1/68</b> 19 <b>68</b> to <b>8/7</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/7</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>C.S. Ming</b>				23B. DATE SIGNED <b>8/7/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>CHEE. SHWE MING</b>				23D. ADDRESS <b>Lutheran Hospital of Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/9/'68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>John A. Moran, Inc.</b>			
25D. ADDRESS <b>3000 E. Balto. St.</b>					

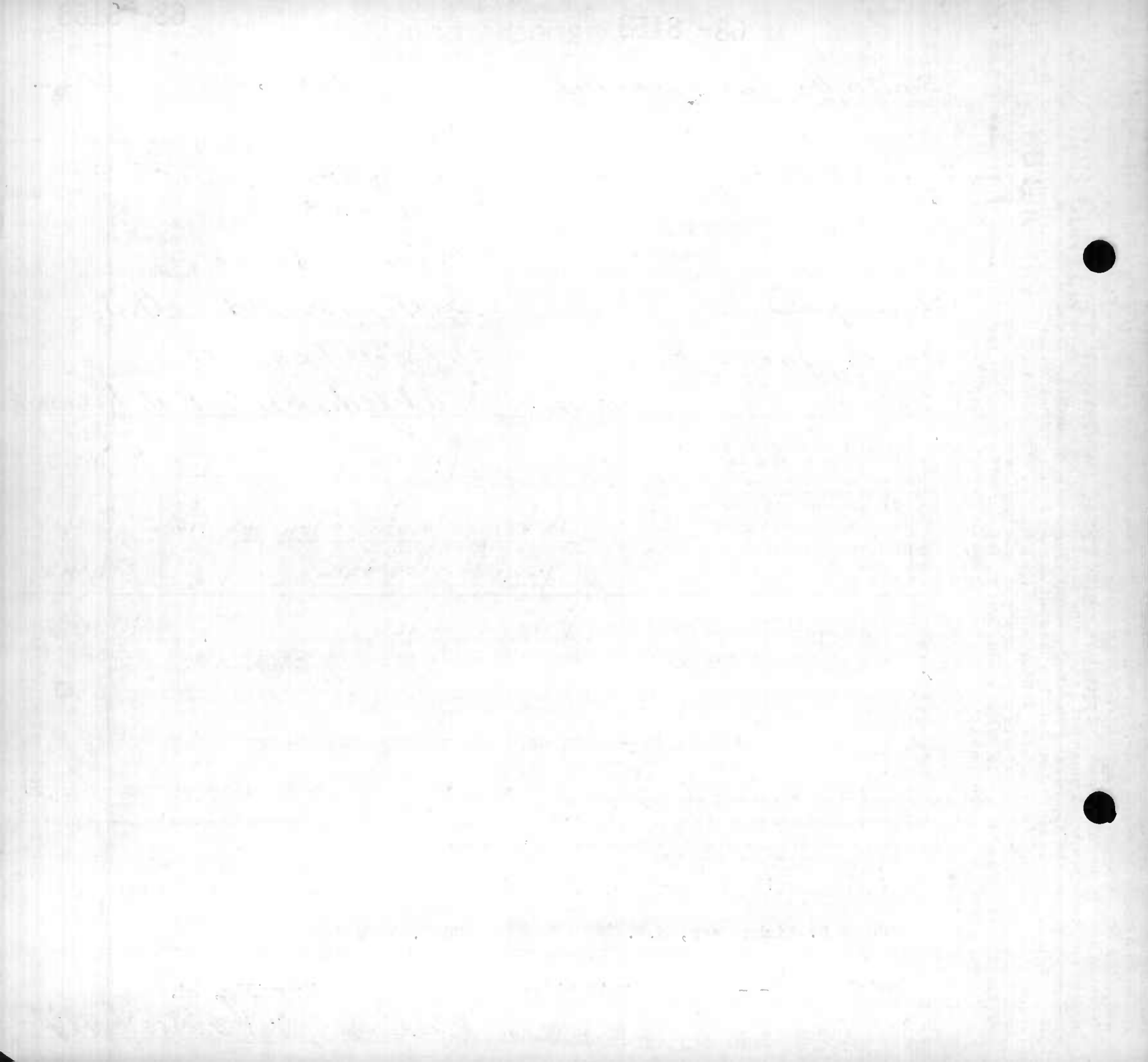


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8158 CERTIFICATE OF DEATH

REG. NO. 68- 8158

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Smith Howard Franklin</i>		2. DATE AND HOUR OF DEATH <i>August 6, 1968</i> <i>11:45 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Keswick</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Keswick Home for Incurables</i> <i>70</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>700 W. 40th St.</i>	
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/11/82</i>	9. AGE (In years lost birthday) <i>86 yrs</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lawyer</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
13. FATHER'S NAME <i>Smith James H.</i>		14. MOTHER'S MAIDEN NAME <i>Gibson Frances</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-38-7036</i>		17. INFORMANT <i>M. A. Frederick</i> ADDRESS <i>R.N. Keswick</i>	
18. <i>4124 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pneumonia</i> (B) <i>Atherosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Diabetic Disease</i> (C) <i>Diverterculitis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 hrs.</i> <i>8 yrs</i> <i>34 yrs</i> <i>10 yrs</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>422.1 II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11 Feb</i> 19 <i>63</i> to <i>6 Aug</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>6 Aug</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Aubrey D. Richardson</i>		23B. DATE SIGNED <i>6 Aug 1968</i>		23C. PHYSICIAN'S NAME (Type) <i>Aubrey D. Richardson, M.D.</i>	
23D. ADDRESS <i>700 W. 40th Street</i>		24. LOCATION (City, town, or county) (State) <i>Pikesville, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-8-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Druid Ridge</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Mitchell-Wheeler</i> ADDRESS <i>6500 York Rd</i>	

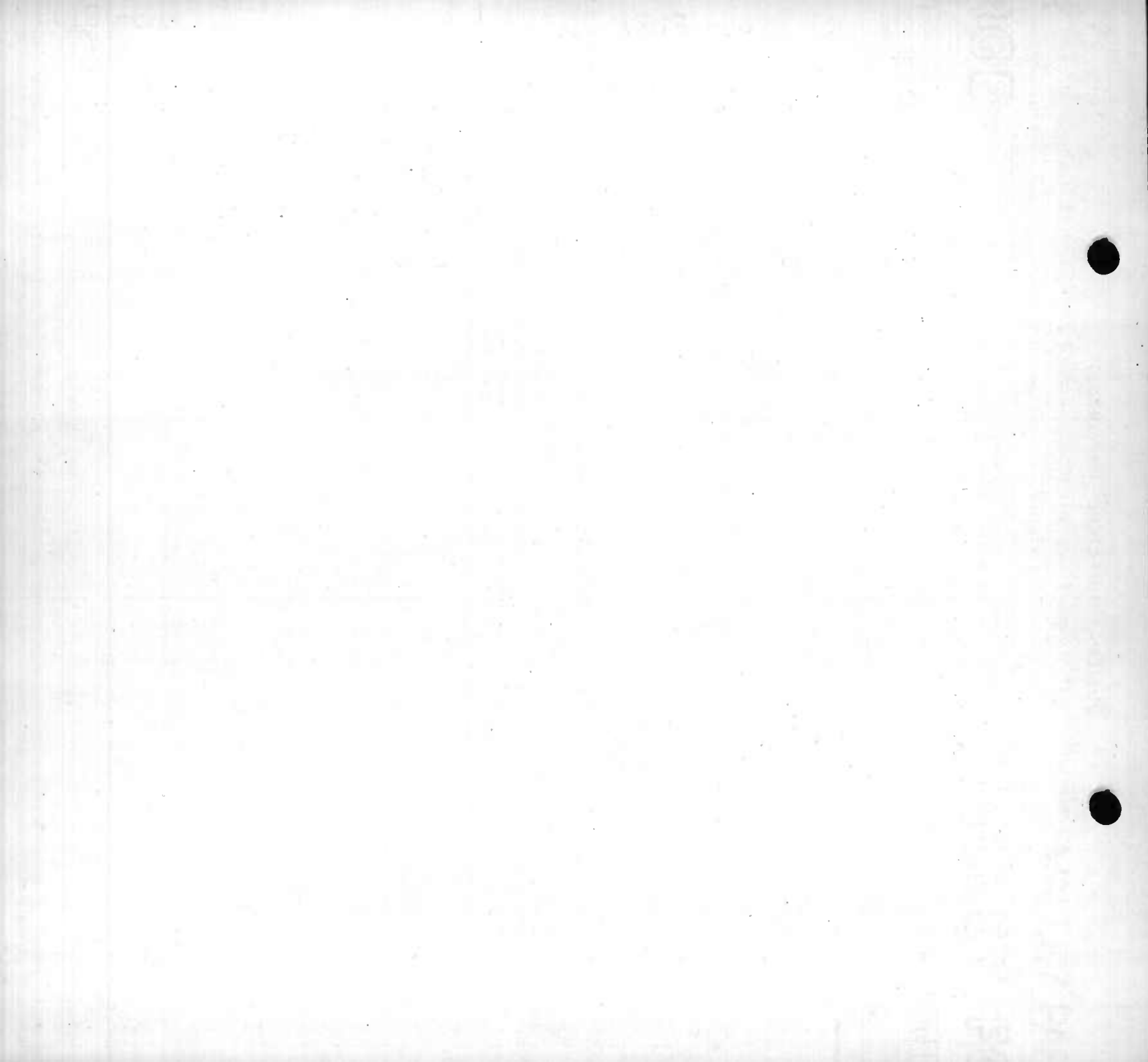


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released as NON MEDICAL CERTIFICATION by the Medical Examiner's Office of Springdale

G 420		68-8159		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 06 2683 8159	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) <u>Giles, WALTER E.</u>				2. DATE AND HOUR OF DEATH <u>10 AM 8/8/68</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> Balto B. COUNTY <u>Balto</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 Johns Hopkins Hosp</u>				C. CITY OR TOWN <u>Balto</u>		D. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>1604 Greenmount Ave.</u>			
5. SEX <u>Male</u>	6. RACE <u>Negroid</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-23-23</u>	9. AGE (In years lost birthday) <u>45</u>	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTO, MD.</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>FREEMAN GILES</u>			
14. MOTHER'S MAIDEN NAME <u>Sarah Cushman</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWII</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mrs Sarah Giles 1604 Greenmount Ave.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>277X I</u> (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Respiratory + Cardiac arrest Immed</u> (B) <u>Shock, Hypotension</u> (C) <u>Metabolic Acidosis, hepatic failure</u> <u>Possible Ingestion, Sepsis</u>			
19. DATE OF OPERATION <u>289.2 II</u>				20. AUTOPSY? (Yes or No) <u>Yes</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>8/7</u> 19 <u>68</u> to <u>8/8/</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8/8/</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE <u>Marc Lippman MD</u> DEGREE			
23B. DATE SIGNED <u>8/8/68</u>				23C. PHYSICIAN'S NAME (Type) <u>MARC Lippman MD</u> DEGREE			
23D. ADDRESS <u>J.H.H. Baltimore</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>8/13/68</u>				24C. NAME OF CEMETERY or CREMATORY <u>Balto. National Cem.</u>			
24D. LOCATION (City, town, or county) (State) <u>Balto MD.</u>				25A. DATE REC'D BY HEALTH DEPT. <u>AUG 12 1968</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farkas</u>				25C. FUNERAL DIRECTOR <u>WM MARCH 928 E. North Ave.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">J.</span>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">68- 8160</span>	
1. NAME OF DECEASED (Type or Print) <b>EMMA MOORE (Cunningham)</b>				2. DATE AND HOUR OF DEATH <b>8/8/68 10:15 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>MARYLAND, BALTO</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>JOHN HOPKINS HOSPITAL</b>				C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
CERTIFICATE AMENDED <b>8/14/68</b>				E. STREET AND NUMBER <b>1045 N BROADWAY</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>NEGROID</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/23/21</b>		9. AGE (In years last birthday) <b>46</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>ERNEST CUNNINGHAM</b>				14. MOTHER'S MAIDEN NAME <b>EMMA BARCO</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-24-1792</b>		17. INFORMANT ADDRESS <b>MR THEOPHER MOORE 1045 BROADWAY</b>			
18. <b>285.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Cardio-Respiratory Arrest</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>ANEMIA, PERICARDIAL EFFUSION, abd. Tumor</b> <b>Etiology unknown</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>293X II</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>August 8, 1968 9:00 P.M.</b> to <b>August 8, 1968 6:30 P.M.</b> that (I) (we) lost saw the deceased alive on <b>August 8</b> 19 <b>68</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Edward D. Hank Jr. M.D.</b>				23B. DATE SIGNED <b>8/8/68</b>			
23C. PHYSICIAN'S NAME (Type) <b>Edward D. Hank Jr. M.D.</b>				23D. ADDRESS <b>1519 E. Monument St. Baltimore, Md. 21205</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/13/68</b>		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) <b>ELIZABETH CITY, N.C.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>WM. C. MARCH</b>		ADDRESS <b>928 E NORTH AVE</b>	

8/16/68 - Correction form from funeral director.

*L. B. Carter*

RECEIVED

Aug 17 1968

10/17/68

10/17/68

1  
R-152

68- 8161 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8161

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

KENNARD

ROBINSON

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

August 8, 1968

2:20 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 309 N. Stricker Street

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

August 8, 1968

2:20 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

10-10-1902

10. AGE (In years  
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

309 N. Stricker Street

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF

WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

RETAILER

14B. KIND OF BUSINESS OR INDUSTRY

PAVING CONTRACTOR

15. MOTHER'S MAIDEN NAME

Lillian

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL SECURITY NO.

18. INFORMANT

Marydove 309 N. Stricker St

ADDRESS

19. 412, 41

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

20. ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

422, 1

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 9, 1968

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8/12/68

24C. NAME of CEMETERY or CREMATORY

Mt Auburn

24D. LOCATION (City, town, or county)

Baltimore

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 12 1968

25B. NAME OF REGISTRAR

Robert E. Farkas

25C. FUNERAL DIRECTOR

Mrs. Sam P. Hays

ADDRESS

135 N. G. Lane St

313-83

1918

WALTER H. HARRIS  
WALTER H. HARRIS

WALTER H. HARRIS

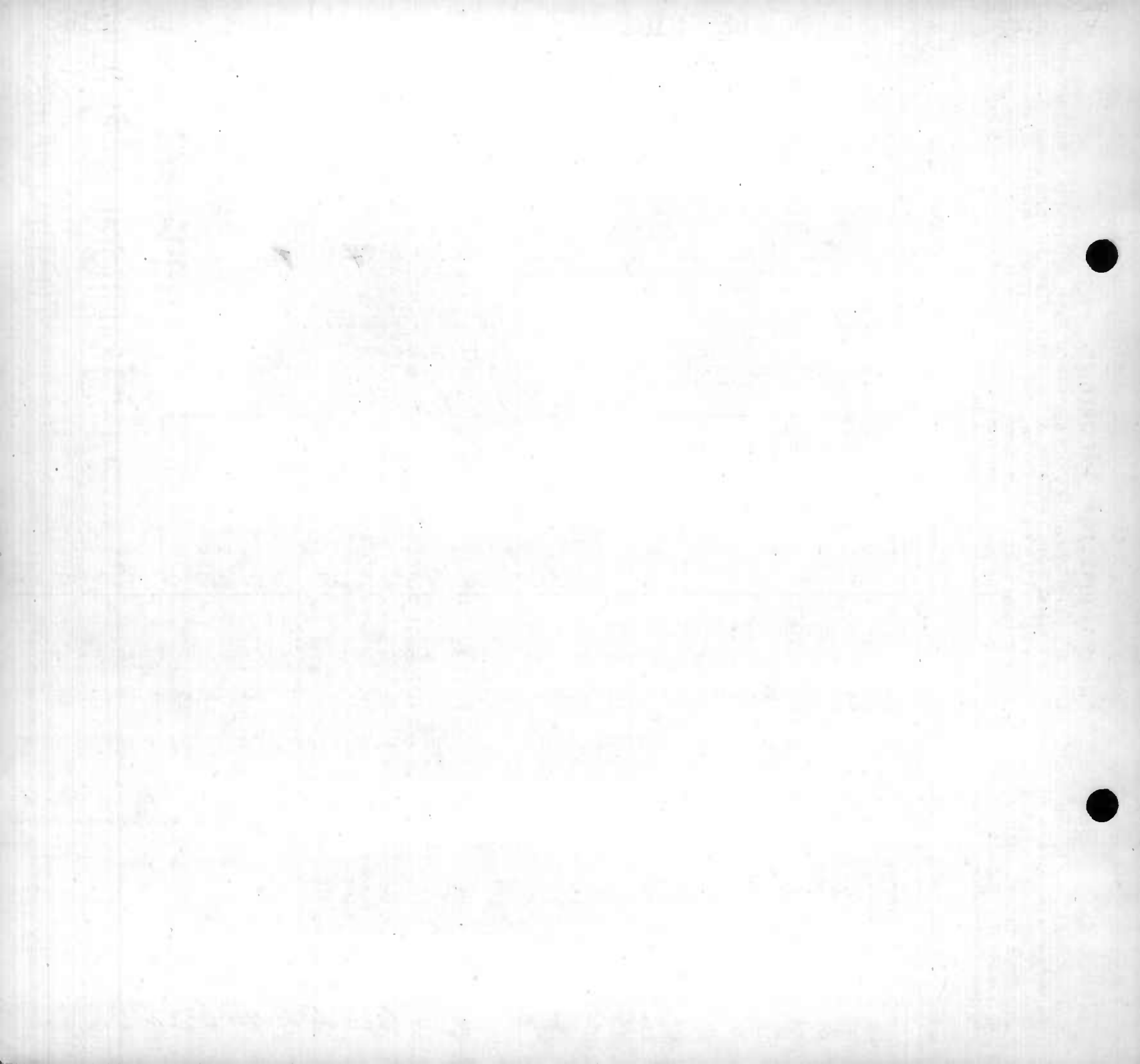
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8162 CERTIFICATE OF DEATH

REG. NO. 68- 8162

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ROSA PEAY</b>		2. DATE AND HOUR OF DEATH <b>8/9/68 9:00 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md.</b> B. COUNTY <b>16-08</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>George Washington Nursing Home 607 Penns. Ave. Baltimore md. 21201</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>Female</b>	6. RACE <b>Amer. Negra</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 12, 1894</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months: Days: <b>2 27</b> If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	
13. FATHER'S NAME <b>?</b>			14. MOTHER'S MAIDEN NAME <b>DIANE CUNNINGHAM</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-56-9004</b>		17. INFORMANT <b>CHART.</b>	
18. <b>412.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>420.0 II</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Bronchial Pneumonia</b> (B) <b>Pericard. Sec Heart disease</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Chr. Brain Syndrome</b> (C) <b>Chr. Brain Syndrome</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>Unknown</b> <b>Unknown</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/9</b> <b>9/11</b> <b>19 67</b> to <b>8/9/</b> <b>19 67</b> , that (I) (we) lost saw the deceased alive on <b>8/9</b> <b>19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Edmund C. Heist md</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>EE Holt md</b>				23D. ADDRESS <b>3715 Liberty Heights Ave. Balt. md 21216</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>8/10/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>WINNABORO S.C.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Marshall P. Hays</b>	
				ADDRESS <b>631 N. Gilmor</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 8163 CERTIFICATE OF DEATH

REG. NO. 68- 8163

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BLAZER, MARY A.</b>		2. DATE AND HOUR OF DEATH <b>8-10-68</b> <b>I:30 P</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>BOLT ON HILL NURSING CENTER</b> <b>90</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>220 MASON COURT</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-01-77</b>	9. AGE (In years lost birthday) <b>91</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>	
13. FATHER'S NAME <b>Smelter</b>			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-08-9696T</b>		17. INFORMANT <b>ADMISSION RECORD</b>	
18. <b>595X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Hemorrhagic cystitis</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>proteus mirabilis</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b> <b>2 mos.</b>					
18. <b>605X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>anorexia, decubitus ulcer, sacrum</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 mos</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) <b>No injury</b> <b>8:00PM</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8-6-68</b> 19 to <b>8-10-68</b> 19, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>8-10-68</b> 19 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>E. Ellsworth Cook, M.D.</b> DEGREE				23B. DATE SIGNED <b>8-10-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>E. ELLSWORTH COOK, M.D.</b>				23D. ADDRESS <b>2431 Maryland Avenue</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-13-1968</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc.</b>	
ADDRESS <b>1901-07 Eastern Ave.</b>					



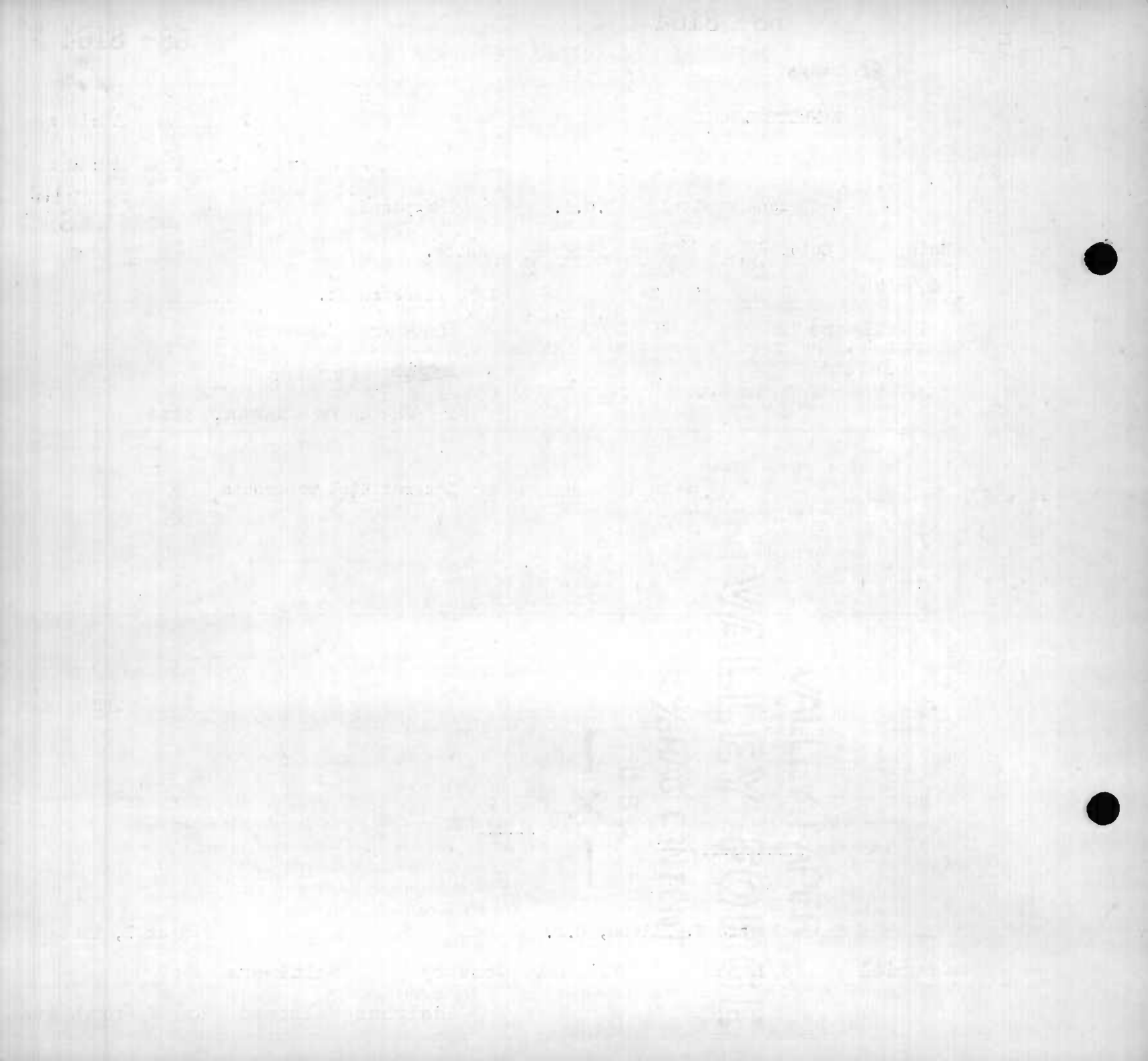
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 8164

BIRTH NO. 68-10440

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>KENNETH LAWSON</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 8 7 68 10:10 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Lutheran Hospital D.O.A.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 7 1968 10:10 a.m.</b>	
6. SEX <b>Male</b>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-02</b>	
7. RACE <b>Colored</b>		C. CITY OR TOWN <b>Balto.</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>6/6/68</b>		E. STREET AND NUMBER <b>1838 Presshan St.</b>	
10. AGE (In years last birthday) <b>2</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>	
12. CITIZEN OF <b>U S A</b>		13. FATHER'S NAME <b>Theodore Lawson</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		15. MOTHER'S MAIDEN NAME <b>Lydia Perkins</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Mr Theodore Lawson, same</b>		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>484X I</b> <b>Interstitial pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>5-25-X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>YES</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Edward F. Wilson, M.D.</b> M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>August 7, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/12/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>National Cemetry</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>1206 W North Ave</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

# 68- 8165 CERTIFICATE OF DEATH

REG. NO.

68- 8165

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Baylor, Joshua</i>		2. DATE AND HOUR OF DEATH <i>Aug. 7/68 6:50 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, (if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>20-01</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>36 FRANKLIN SQUARE Hosp.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITED YES <input type="checkbox"/> NO <input type="checkbox"/>	
S. SEX <i>M</i> 6. RACE <i>N.</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <i>9/5/13</i> 9. AGE (In years last birthday) <i>54</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>GARDNER</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>VA.</i>	
13. FATHER'S NAME <i>V. BAYLOR</i>		14. MOTHER'S MAIDEN NAME <i>SARA JACKSON</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes W W 2</i>		16. SOCIAL SECURITY NO. <i>224-12-5579</i>		17. INFORMANT ADDRESS <i>WILLIAM BAYLOR 4411 CRANSTON AVE</i>	
18. <i>412.21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>CONGESTIVE HEART FAILURE</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>HYPERTENSIVE CARDIOVASCULAR DISEASE</i> DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>443X II</i>		(C) _____			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Aug. 4</i> 19 <i>68</i> to <i>Aug. 7</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Aug. 7 6:50 PM</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Chulwon Kwon, M.D.</i>		23B. DATE SIGNED <i>Aug 7/68</i>		23C. PHYSICIAN'S NAME (Type) <i>CHULWON KWON M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/13/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>National Cemetry</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 12 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairbanks</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Adolphus Halstead 1206 W North Ave</i>	

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8166

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

REG. NO. 68- 8166

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Samuel Robert</i>		2. DATE AND HOUR OF DEATH <i>Aug - 10 - 1968</i>   <i>5 30</i> PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Peninsula Nursing Home</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffer</i>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>12-25-84</i>	
13. FATHER'S NAME <i>William</i>		14. MOTHER'S MAIDEN NAME <i>Julia</i>		9. AGE (In years last birthday) <i>83</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes</i> <i>W W I</i>		16. SOCIAL SECURITY NO. <i>218-05-7119</i>		11. BIRTHPLACE (State or foreign country) <i>Savannah Georgia</i>	
18. <i>7-3391</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral Thrombosis</i>		CAUSE OF DEATH		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7-27</i> 19 <i>68</i> to <i>8-10</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>8-10</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <i>Hollis DeMarine</i>				23B. DATE SIGNED <i>8-10-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Hollis DeMarine</i>		23D. ADDRESS <i>5519 Kennison Avenue Park Rd</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/15/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>National Cemetry</i>	
24D. LOCATION <i>Baltimore Md</i>		25A. DATE RECEIVED BY HEALTH DEPT. <i>Aug 12 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Adolphus Halstead</i>			
25D. ADDRESS <i>1206 W North Ave</i>					

James H. [Signature]  
James H. [Signature]  
James H. [Signature]

W-345

68- 8167 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8167

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JEROME WOODLAND</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input checked="" type="checkbox"/> <b>August 1, 1968</b> <b>UNK</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2300 blk. Pennsylvania Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 5, 1968 2:00 P.M.</b>	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH <b>3/5/33</b>	
10. AGE (In years lost birthday) <b>33</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF <b>WHAT COUNTRY?</b>		13. FATHER'S NAME <b>John Woodland</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		15. MOTHER'S MAIDEN NAME <b>Margaret</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Mrs Rosie Jackson,</b>		ADDRESS	

19. <b>79612</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Advanced Decomposition. No Cause of</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Death Determined at Autopsy.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>79513</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
20A. DATE OF OPERATION	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>		
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> EXAMINER'S NAME (Type)		DATE SIGNED <b>8/6/68</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8-10-68</b>	24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cmn.</b>
24D. LOCATION (City, town, or county) (State) <b>Balta - Md.</b>	25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 12 1968</b>	25B. NAME OF REGISTRAR <b>Robert E. Sullivan</b>
25C. FUNERAL DIRECTOR <b>A. Helstead</b>	ADDRESS <b>918 - Duval Hill</b>	

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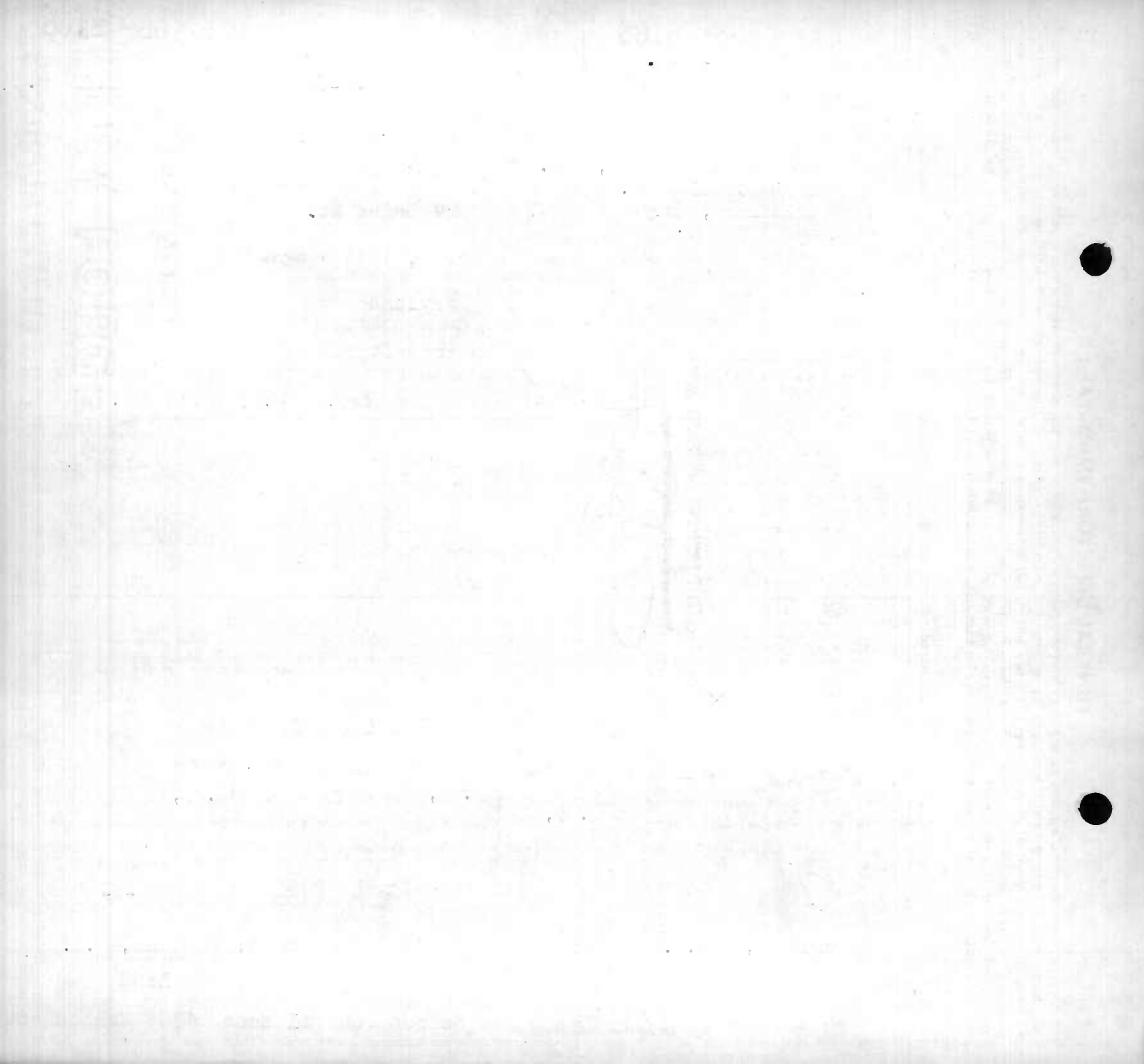
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 68- 8168 CERTIFICATE OF DEATH

REG. NO. 68- 8168

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Pearl Brooks</b>		2. DATE AND HOUR OF DEATH <b>8-7-68</b>   <b>8:30 p.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		5. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>39</b> <b>Provident Hospital, Inc.</b> <b>1514 Division St.</b> <b>Baltimore, Maryland 21217</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>527 Brice St.</b>		6. DATE OF BIRTH <b>Nov 3, 1911</b>		9. AGE (In years last birthday) <b>56</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Henry Williams</b>		14. MOTHER'S MAIDEN NAME <b>Rose Stream</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-03-1855</b>		17. INFORMANT <b>Helen Huges</b> 1805 Ensor St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of death, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Heat stroke</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b>		19. CAUSE OF DEATH <b>Heat stroke</b>	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) noting the UNDERLYING CONDITION last.		21. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		22. DUE TO, OR AS A CONSEQUENCE OF:	
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		24. DATE OF OPERATION <b>8-7-68</b>		25. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>4 PM</b>	
26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>LAUNDRY</b>		28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>FISH LINEN Co, 2565 PENNA. AVE.</b>	
29. TIME OF INJURY (APPROX.) <b>8-7-68</b>		30. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		31. HOW DID INJURY OCCUR? <b>COLLAPSED AT WORK</b>	
32. I certify that (I) (this hospital) attended the deceased from <b>Aug. 7, 1968</b> to <b>Aug. 7, 1968</b> and that (I) (we) last saw the deceased alive on <b>Aug. 7, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		33. SIGNATURE <b>Muhussy</b>		34. DATE SIGNED <b>8-8-68</b>	
35. PHYSICIAN'S NAME (Type) <b>Muhussy M.D.</b>		36. ADDRESS <b>1514 Division Street; Baltimore, M.D.</b>		37. DATE <b>8/10/68</b>	
38. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		39. NAME OF CEMETERY or CREMATORY <b>New Cathedral</b>		40. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
41. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		42. NAME OF REGISTRAR <b>Robert E. Taylor</b>		43. FUNERAL DIRECTOR <b>Kelson Funeral Home</b>	
44. ADDRESS <b>1348 Calhoun St</b>		45. ADDRESS <b>1348 Calhoun St</b>		46. ADDRESS <b>1348 Calhoun St</b>	



**FUNERAL DIRECTOR: IMPORTANT**

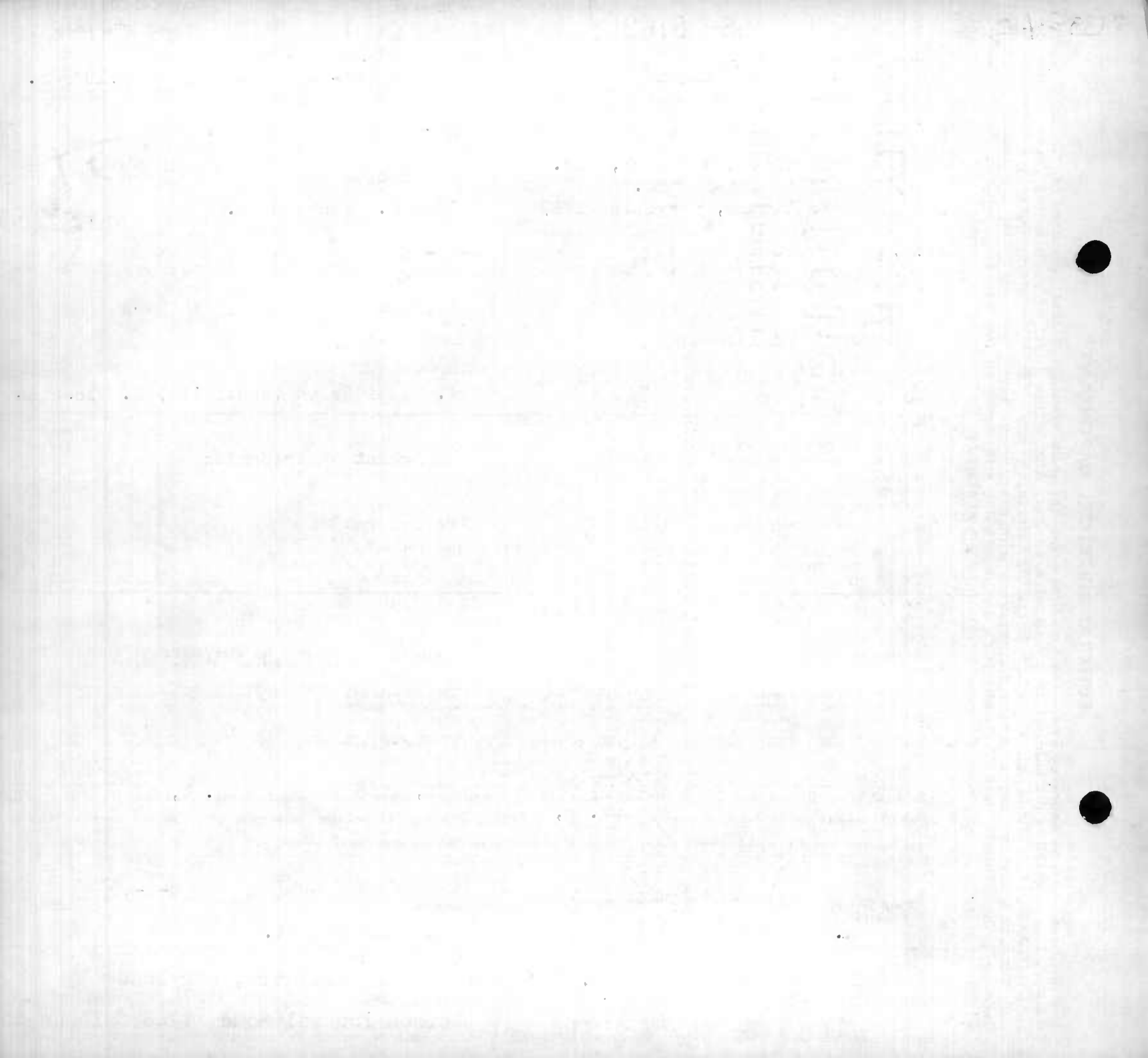
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8169

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

REG. NO. 68- 8169

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Esther Wilson</b>		2. DATE AND HOUR OF DEATH <b>8-8-68</b>   <b>3:10</b> a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>39 Provident Hospital, Inc. 1514 Division St. Baltimore, Maryland 21217</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>YES</b> E. STREET AND NUMBER <b>1103 N. Stockton St.</b>	
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-10-34</b>	9. AGE (In years lost birthday) <b>34</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Herbert Tomlin</b>		14. MOTHER'S MAIDEN NAME <b>Letta Wright</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Naomi Smith (Aunt) 1117 N. Stockton</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>400.13 Malignant Hypertension</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>443.5X II Uremia</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 31, 1968</b> 19 to <b>Aug. 8, 1968</b> 19 that (I) (we) last saw the deceased alive on <b>Aug. 8, 1968</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>A. Khaliq</b>				23B. DATE SIGNED <b>8-8-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>A. Khaliq</b>		23D. ADDRESS <b>1514 Division St.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/12/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Balto. National</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Kelson Funeral Home 1348 Calhoun St</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. **68- 8170**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARIE H. CIHLAR</b>		2. DATE AND HOUR OF DEATH <b>9th. Aug 68 10500 hrs.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balto Co</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hospital Baltimore 1,</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>5727 Arnhem Road ARNHAM RD</b>		
5. SEX <b>Female</b>	6. RACE <b>Caucasoid</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/01/30</b>	9. AGE (In years last birthday) <b>37 yrs.</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Westinghouse</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>	
13. FATHER'S NAME <b>Emil Vorel.</b>			12. CITIZEN OF WHAT COUNTRY? <b>United States.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>212-28-8100</b>		17. INFORMANT <b>Carl Cihlar, husband, above</b>
18. <b>571.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory failure</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last. <b>Atelectasis and ascites</b>			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>massive cirrhosis of liver.</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>581.0 II</b>					
19A. DATE OF OPERATION <b>581.0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Delfa C. Gomez, D.D.</b>				23B. DATE SIGNED <b>8/9/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Delfa C Gomez, MD</b>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/12/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>	
ADDRESS					

2131 William F. Cook

11/01/30 37 de

William F. Cook  
Malle 102422

William F. Cook

William F. Cook  
Malle 102422

William F. Cook

11/01/30 37 de

✓

William F. Cook

William F. Cook

William F. Cook

11/01/30 37 de

William F. Cook

X

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

50-44-28 LB

R-120

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8171 CERTIFICATE OF DEATH

REG. NO.

68- 8171

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)PETER STEVE RIVAS or  
PETER Rivas ESTEVE

2. DATE AND HOUR OF DEATH

8-8-68 4:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)BALTIMORE CITY HOSPITALS  
4940 EASTERN AVE.,  
BALTIMORE, MD. 212244. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND BALTIMORE

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐ NO ☒

E. STREET AND NUMBER

2848 PLAINFIELD ROAD 21222 005

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

11-29-91

9. AGE (In years  
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Baker

10B. KIND OF BUSINESS OR INDUSTRY

Own Business

11. BIRTHPLACE (State or foreign country)

Spain

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

STEVE RIVAS

14. MOTHER'S MAIDEN NAME

Jennie Alcaraz

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

217-22-1900 A

17. INFORMANT ADDRESS

RECORDS: BALTIMORE CITY HOSPITALS  
4940 EASTERN AVE., BALTO., MD. 2122418. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

420.1 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8-6-19 68 to 8-8-19 68,  
that (I) (we) last saw the deceased alive on 8-8-19 68 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Paul N. Kalkut, M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

8-8-68

23C. PHYSICIAN'S  
NAME (Type)

PAUL N. KALKUT, M.D.

23D. ADDRESS

BALTIMORE CITY HOSPITALS  
4940 EASTERN AVE., BALTO., MD. 2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8/12/68

24C. NAME OF CEMETERY or CREMATORY

Holy Redeemer Cemetery

24D. LOCATION

Baltimore, Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 12 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

ADDRESS

2601 E. Madison St.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

52-32-77		B-236		68-8172		BALTIMORE CITY HEALTH DEPARTMENT		88-8172	
BIRTH NO.		14275		CERTIFICATE OF DEATH		REG. NO.			
1. NAME OF DECEASED (Type or Print)		BAXTER, BABY BOY		2. DATE AND HOUR OF DEATH		8/7/68		5:45:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		BAXTER, BABY BOY Robert W.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland		Baltimore		53-00	
BALTIMORE CITY HOSPITAL		49 40 EASTERN AVE., BALTO., MD. 21224		C. CITY OR TOWN		D. INSIDE CITY LIMITS?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER		7291 Holabird Avenue		21222					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	1 Yr. Days	If Under 24 Hrs. Hours	24 Hrs. Min.	
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8/4/68	3 day	3	12	12		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
none		NONE		BALTIMORE CITY HOSPITAL MARYLAND		U. S. A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
ROBERT A BAXTER		SHARON FAGAN							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO		NONE		RECORDS: BALTIMORE CITY HOSPITALS		4940 EASTERN AVE., BALTO., MD. 21224			
18. 743.9 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Cardiac arrest							
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES		respiratory arrest							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:							
		(C) CMS - defect							
75-3.1 II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		aspiration pneumonia, atelectasis					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
NONE				Yes		YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 8-4- to 8-7- 19 68, that (I) (we) lost saw the deceased alive on 8-7- 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE		23B. DATE SIGNED							
J. A. SENSENBRENNER, M.D.		8/7/68							
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS							
JA SENSENBRENNER		4940 EASTERN AVE., BALTO., MD. 21224							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		8/9/68		Gardens of Faith Cem.		Baltimore, Md.			
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
AUG 12 1968		Philip E. Sank, Jr.		Schimunek Funeral Home, Inc.		3331. Brehms Lane			

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Section of handwritten text in the lower middle part of the document.

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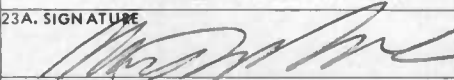
FUNERAL DIRECTOR: IMPORTANT

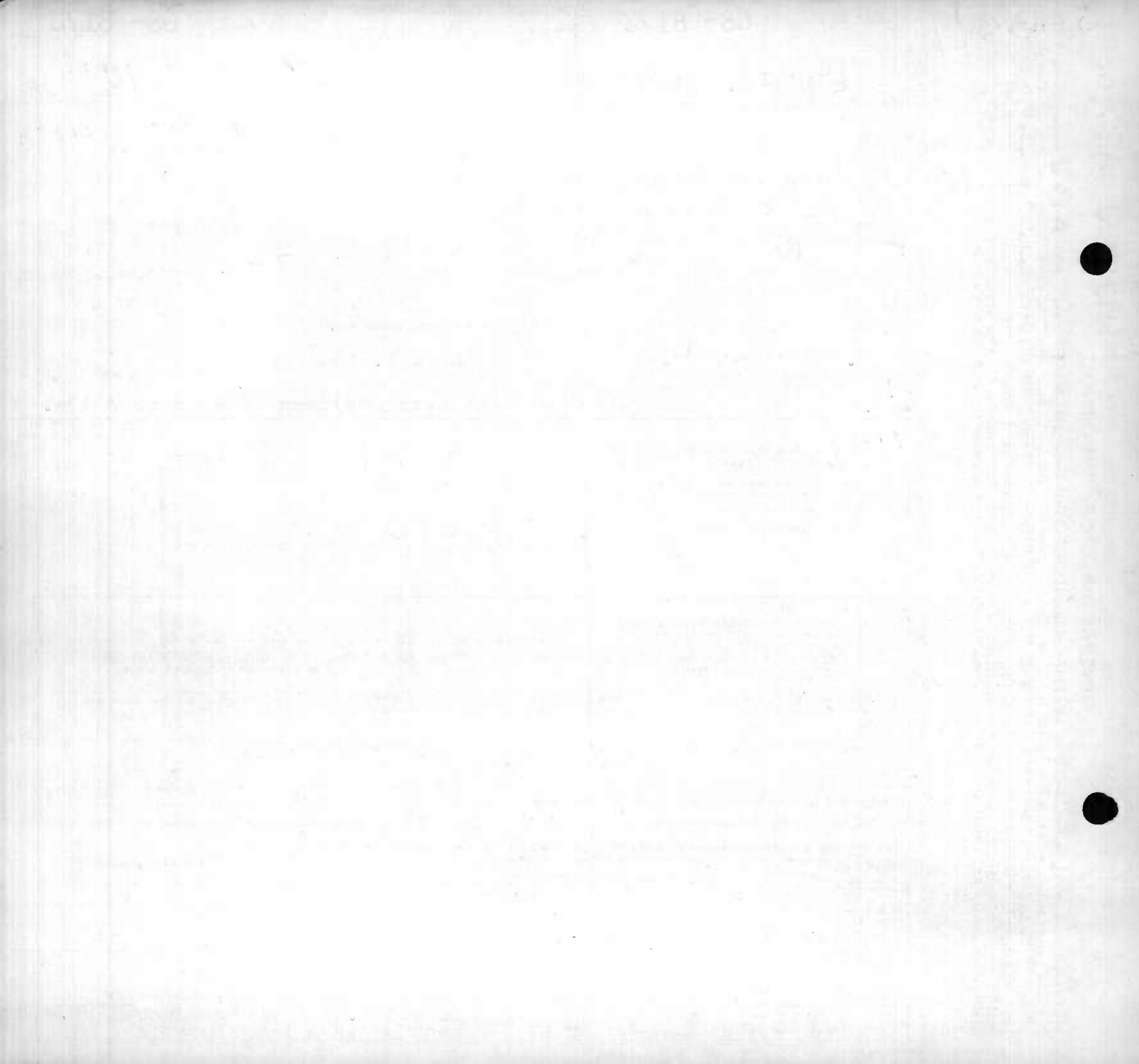
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8173

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 8173

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>EDNA M. WALTERS</b>		2. DATE AND HOUR OF DEATH <b>8/6/68 10<sup>22</sup> P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hosp. of Balto., Inc.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Belvedere &amp; Greenspring Aves.</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>5/16/96</b>		9. AGE (In years last birthday) <b>72</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>John M. Meerdtter, Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Annie E. Kaufman</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>W</b>		16. SOCIAL SECURITY NO. <b>212-14-1263</b>		17. INFORMANT ADDRESS <b>Kenneth Walters 3042 Second Ave.</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarct.</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 hrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ASCD</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>420.1 II</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/4</b> 19 <b>68</b> to <b>8/6</b> 19 <b>68</b> , that (I) ( <del>We</del> ) last saw the deceased alive on <b>8/6</b> 19 <b>68</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did</del> ) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED <b>8/6/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>STEPHEN D. ROSENBAUM MD</b>		23D. ADDRESS <b>Sinai Hosp. of Balto., Inc. Belvedere &amp; Greenspring Aves.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/9/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Meadow Ridge Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taniguchi</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Robert C. Altenburg Funeral Home, Inc. 6009 Harford Road 21214</b>			

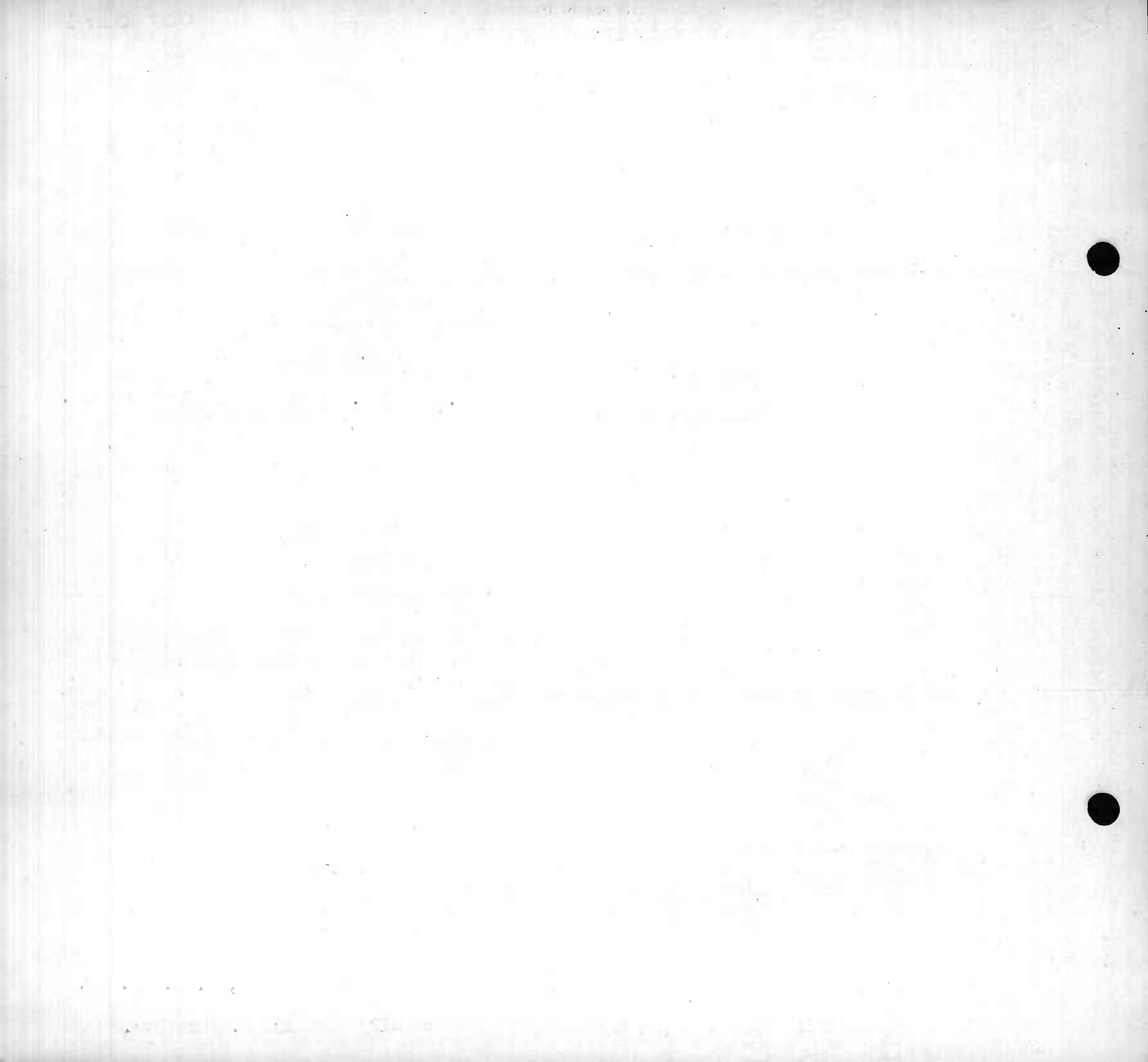


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8174 CERTIFICATE OF DEATH

REG. NO. 68- 8174

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Anthony Ricci</i>		2. DATE AND HOUR OF DEATH <i>8/7/68</i> <i>11 P</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 University Hospital</i>			C. CITY OR TOWN <i>BA/6.</i>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <i>1137 Cleveland St.</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/25/00</i>	9. AGE (In years last birthday) <i>67</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook-retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Food</i>	11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>Michael Ricci</i>			14. MOTHER'S MAIDEN NAME <i>Isabel Unknown</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-05-5453</i>	17. INFORMANT ADDRESS <i>Mrs. Edith M. Ricci 1137 Cleveland St.</i>		
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>420.1 II</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <i>8/7</i> 19 <i>68</i> to <i>8/7</i> 19 <i>68</i> , that (I) ( <del>we</del> ) lost saw the deceased alive on <i>8/7</i> 19 <i>68</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <i>Gary Marc Lattin M.D.</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>GARY MARC LATTIN M.D.</i>				23D. ADDRESS <i>University Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8 10 68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Glen Haven</i>	
24D. LOCATION (City, town, or county) (State) <i>Glen Burnie, A. A. Co. Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 12 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairburn</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Mc Cully 130 E. Fort Ave.</i>	

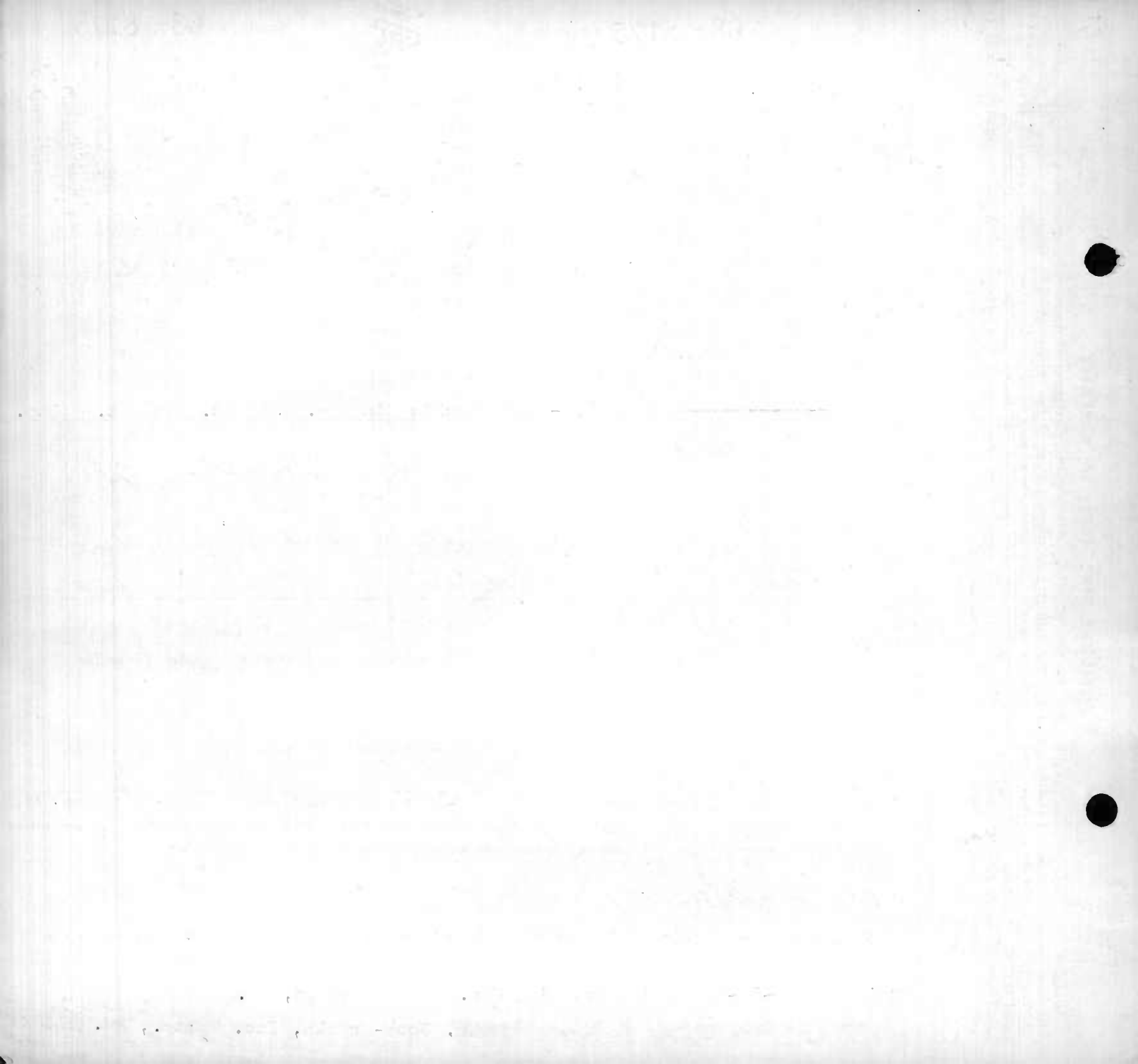


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8175 CERTIFICATE OF DEATH

REG. NO. 68- 8175

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Margaret King</i>		2. DATE AND HOUR OF DEATH <i>August 7, 1968</i> <i>6<sup>30</sup> A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balto.</i>		5. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Boston Hill Hosp. &amp; Convalescent Home</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>1607 St. Paul St. 21202</i>	
5. SEX <i>F</i>	6. RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/4/04</i>	9. AGE (In years last birthday) <i>64</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Pa.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Tayner, Frank</i>		14. MOTHER'S MAIDEN NAME <i>?????</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>409/54-0895</i>		17. INFORMANT <i>Archie King Jr. 1611 St. Paul St. Balto.</i>	
18. <i>412.21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>cerebral vascular occlusion expected</i> (B) <i>arteriosclerotic disease</i> (C) <i>hypertension</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3/68</i> <i>years</i> <i>years</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>443X II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3/5</i> <i>1968</i> to <i>8/7</i> <i>1968</i> , that (I) (we) last saw the deceased alive on <i>8/7</i> <i>1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Alan H. Macht</i>		23B. DATE SIGNED <i>8/7/68</i>		23C. PHYSICIAN'S NAME (Type) <i>ALLAN H. MACHT MD</i>	
23D. ADDRESS <i>2 E. READ ST. Balto Md 21202</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-10-1968</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Prospect Hill Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Towson, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 12 1968</i>	
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Wm. Cook-Brooks, Inc. Balto., Md. 21202</i>		ADDRESS	



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68- 8176 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8176

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOHN W. ROBERTS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>8</b> Day <b>8</b> Year <b>1968</b> Hour <b>5:05A</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>1828 St. Paul Street</b>		3. DATE PRONOUNCED DEAD Month <b>August</b> Day <b>8</b> Year <b>1968</b> Hour <b>5:05 A.</b> M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1205</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>Male</b>	7. RACE <b>White</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	E. STREET AND NUMBER <b>1828 St. Paul Street</b>
9. DATE OF BIRTH <b>3-22-1901</b>		10. AGE (In years lost birthday) <b>67</b>	11. BIRTHPLACE (State or foreign country) <b>Easton, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Roberts</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>	
15. MOTHER'S MAIDEN NAME <b>Augusta Eilerman</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>	
17. SOCIAL SECURITY NO. <b>220-03-5577</b>		18. INFORMANT <b>Donald Roberts</b>	
19. <b>412.7</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		19. <b>412.7</b> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic cardiovascular disease</b>	
20. DATE OF OPERATION		21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>August 8, 1968</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-10-1968</b>	
24C. NAME of CEMETERY or CREMATORY <b>Meadowridge Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Dorsey, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks, Inc. Balto., Md. 21202</b>		ADDRESS	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 68- 8177 CERTIFICATE OF DEATH

REG. NO. **68- 8177**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MURIEL I. MCCOSH</b>		2. DATE AND HOUR OF DEATH <b>AUGUST 8, 1968 3:05 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 THE UNION MEMORIAL HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>11-01</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>221 E. BIDDLE STREET</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 12, 1885</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>LONDON XXX ENGLAND Toronto CANADA</b>	
13. FATHER'S NAME <b>FRANK ? SPELLER</b>			14. MOTHER'S MAIDEN NAME <b>GEAN CARFRA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-07-9682</b>		17. INFORMANT <b>THE CHART</b> ADDRESS	
18. <b>268X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>794X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>OLD MYOCARDIAL INFARCTION</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ASPIRATION PNEUMONIA</b> (B) <b>PROGRESSIVE CACHEXIA OF UNKNOWN CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ABOUT ONE YEAR</b>
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <b>JULY 31 19 68</b> to <b>AUGUST 8 19 68</b> , that (I) ( <u>we</u> ) last saw the deceased alive on <b>AUGUST 8 19 68</b> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>we</u> ) ( <u>did not</u> ) view the body after death.					
23A. SIGNATURE <b>Chun Kee Rye M.D.</b> OEGREE				23B. DATE SIGNED <b>AUGUST 8, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>CHUN KEE RYO M.D.</b> OEGREE				23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>8-10-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Greenmount Crematory</b>	
24D. LOCATION <b>Balto., Md.</b>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks, Inc. Balto., Md. 21202</b>	

THE UNION MEDICAL HOSPITAL  
 201 E. 6th Street  
 BOSTON  
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 FEMALE WHITE  
 NAME  
 Frank J. Zeller  
 Green Carver  
 THE CHART

Aspiration pneumonia  
 Progressive Degeneration of Lung  
 Cause

OLD MYOCARDIAL INFARCTION

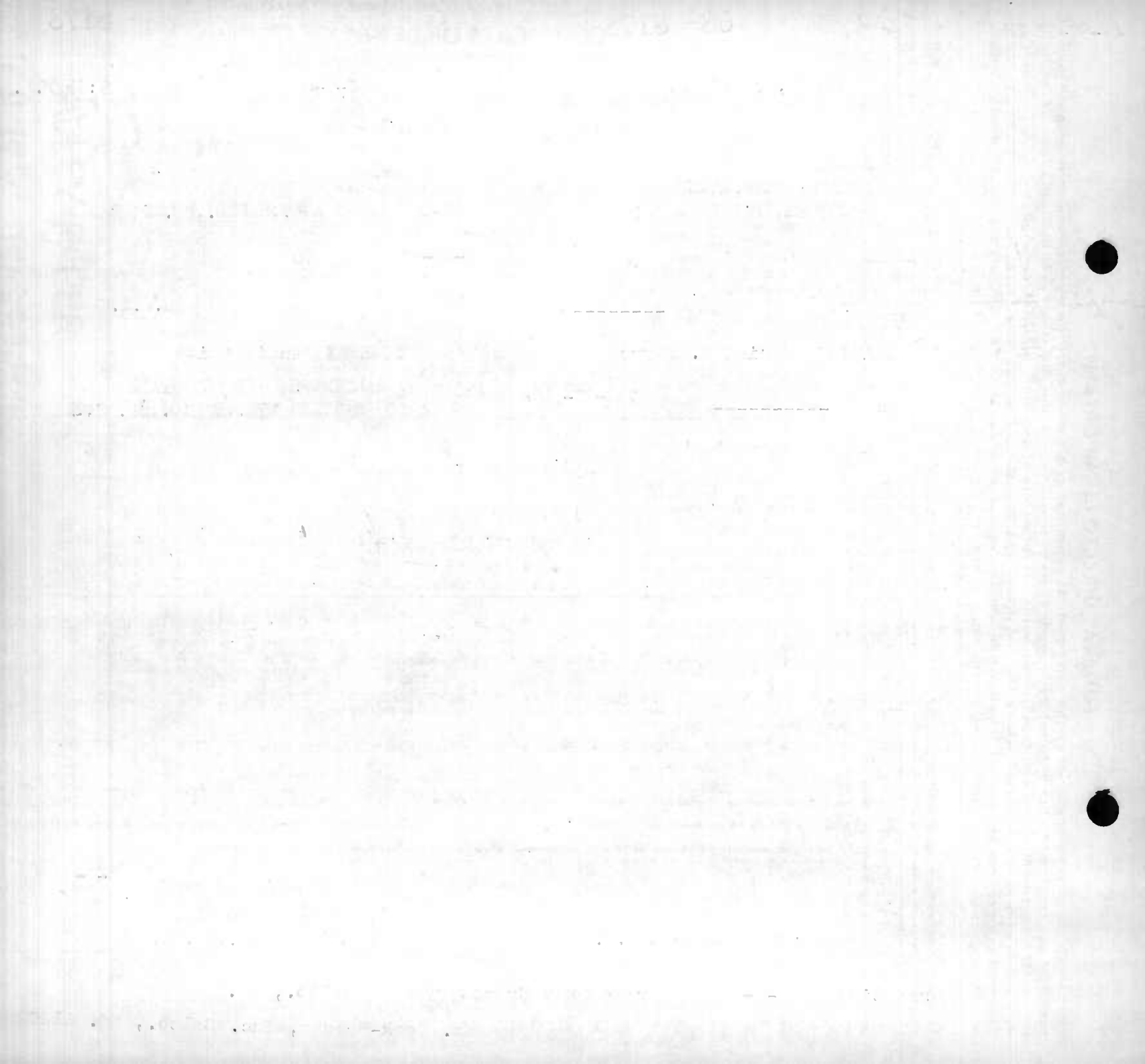
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 (Chas Lee Ryo M.D.)  
 (Chas Lee Ryo M.D.)

47-97-82 LB

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-520		68-8178		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-8178	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>JONES, HENRIETTA</b>			
2. DATE AND HOUR OF DEATH <b>8-7-68 9:15 P.M.</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224</b>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>26-12</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>4940 EASTERN AVE., BALTO., MD. 21224</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-26-91</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>INDIANA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNKNOWN Daniel B. Sayre</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN Annie Smith</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>130-07-3004</b>	
17. INFORMANT <b>RECORDS: BALTIMORE CITY HOSPITALS 4940 EASTERN AVE., BALTO., MD. 21224</b>		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>412.21</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Respiratory Arrest</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertensive &amp; Visceroblastic Cardiorespiratory Disease</b> (C) <b>Chronic Brain Syndrome</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>443X II</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21F. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		22. I certify that <b>15</b> (this hospital) attended the deceased from <b>10/24</b> 19 <b>66</b> to <b>8/7</b> 19 <b>68</b> , that <b>15</b> (we) last saw the deceased alive on <b>8/7</b> 19 <b>68</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>15</b> (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Leonard Feingold</b>		23B. DATE SIGNED <b>8-7-68 8/7/68</b>		23C. PHYSICIAN'S NAME (Type) <b>LEONARD FEINGOLD, M.D.</b>		23D. ADDRESS <b>BALTIMORE CITY HOSPITALS 4940 EASTERN AVE., BALTO., MD. 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>8-9-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Greenmount Crematory</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Feltz</b>		25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks, Inc.</b>		ADDRESS <b>Balto., Md. 21202</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8179 CERTIFICATE OF DEATH

REG. NO. 68- 8179

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>William W. Vaughn</u>		2. DATE AND HOUR OF DEATH <u>8-7-68</u> <u>12 45/P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>44</u> <u>Union Memorial Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>4313 Lasalle Ave</u>	
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-17-88</u>	9. AGE (In years lost birthday) <u>68</u> <u>179</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>33</u>		16. SOCIAL SECURITY NO. <u>577-18-1879</u>		17. INFORMANT <u>Hospital Records</u>	
18. <u>485-X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <u>BRONCHO PNEUMONIA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>PULMONARY EDEMA</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>BRONCHO PNEUMONIA</u> (B) <u>PULMONARY EDEMA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>CS1</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>491X II</u>					
19A. DATE OF OPERATION <u>8</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>8-3-</u> <u>1968</u> to <u>8-7-</u> <u>1968</u> , that (1) <u>we</u> last saw the deceased alive on <u>8-7-</u> <u>1968</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (1) <u>we</u> (did) <u>(did not)</u> view the body after death.					
23A. SIGNATURE <u>Stephen Goldberg</u>		23B. DATE SIGNED <u>8-7-68</u>		23C. PHYSICIAN'S NAME (Type) <u>DR STEPHEN GOLDBERGER</u>	
23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>		23E. ADDRESS <u>2511-0 Steele Rd. 21209</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-10-1968</u>		24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven Mem. Park</u>	
24D. LOCATION <u>Glen Burnie, Md.</u>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 12 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks, Inc. Balto., Md. 21202</u>	

Служба правды

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 68- 8180

BIRTH NO.

 1. NAME OF DECEASED  
(Type or Print)

Eva M. Ensley

2. DATE AND HOUR OF DEATH

8/9/68

9:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00

847 Washington Blvd

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Md

C. CITY OR TOWN

Baltimore

E. STREET AND NUMBER

847 Washington Blvd

D. INSIDE CITY LIMITS?

 YES ☒

 NO ☐

5. SEX

Female

6. RACE

white

 7. MARRIED ☒ NEVER MARRIED ☐

 WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9/30/1887

9. AGE (In years last birthday)

80

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

operator

10B. KIND OF BUSINESS OR INDUSTRY

National Distillery

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Thomas Zanner

14. MOTHER'S MAIDEN NAME

Annie Elliott

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

-

16. SOCIAL SECURITY NO.

215-01-8901

17. INFORMANT

Mr. George Ensley

ADDRESS

above

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Carcinoma Urinary Bladder

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) Metastasis to brain

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 year

1 month

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

Jan 1968

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Car of urinary bladder

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

(If in Baltimore City, give exact location)

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

 While At Work ☐

 Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/6 to 8/9 1968

that (I) (we) last saw the deceased alive on 8/6 1968 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

John P. Urlock Jr

DEGREE

 Attending Phys. ☒

 Med. Director ☐

 Staff Phys. ☐

23B. DATE SIGNED

8/10/68

23C. PHYSICIAN'S NAME (Type)

JOHN P. URLOCK JR

DEGREE

23D. ADDRESS

1227 Washington Blvd

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/13/68

24C. NAME OF CEMETERY or CREMATORY

Cedar Hill Cem.

24D. LOCATION

Ritchie Hwy

(City, town, or county)

Md.

(State)

25A. DATE RECD BY HEALTH DEPT.

AUG 12 1968

25B. NAME OF REGISTRAR

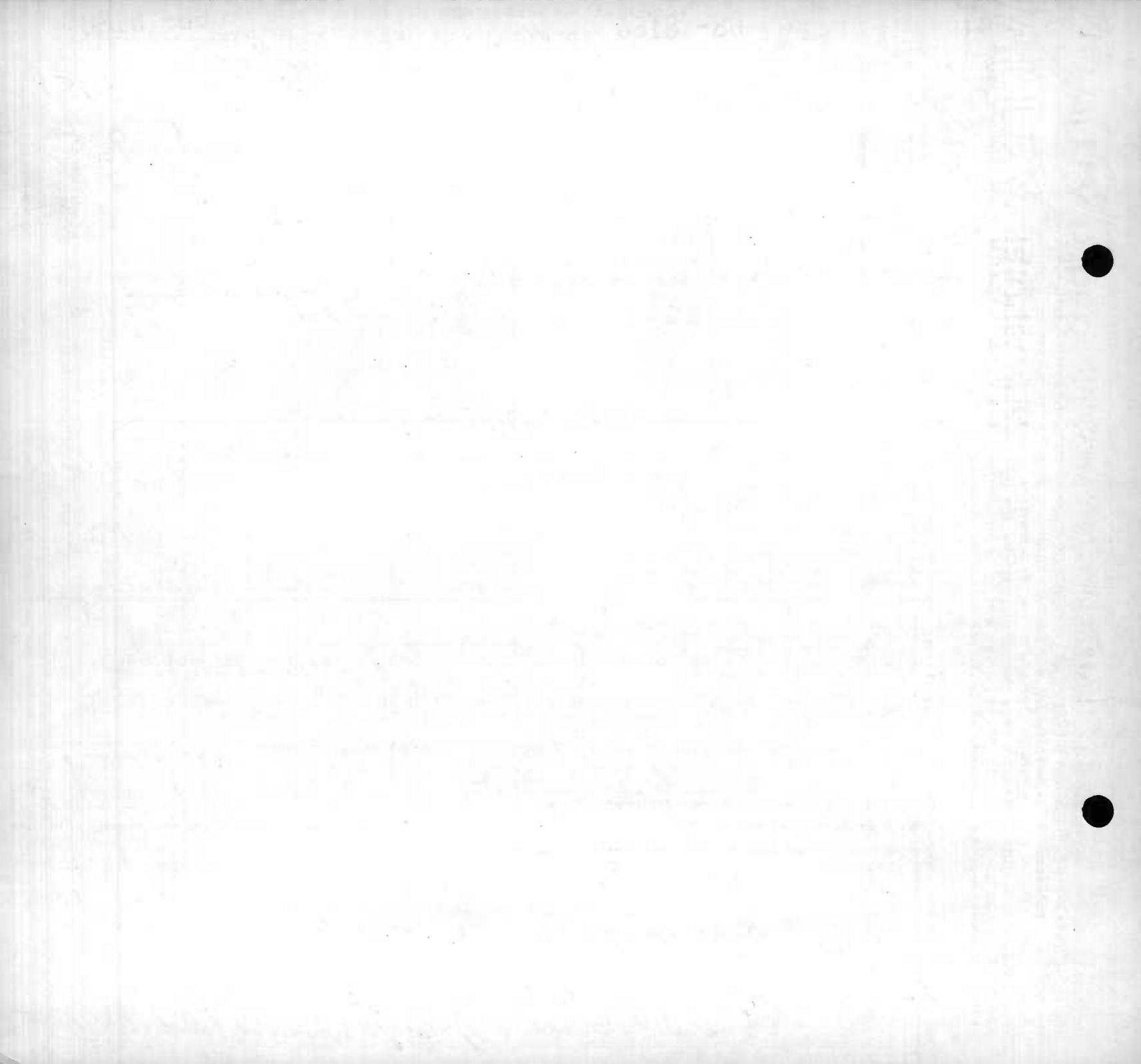
Robert E. Taylor

25C. FUNERAL DIRECTOR

John J. Cowan &amp; Son Inc.

ADDRESS

23, Md.



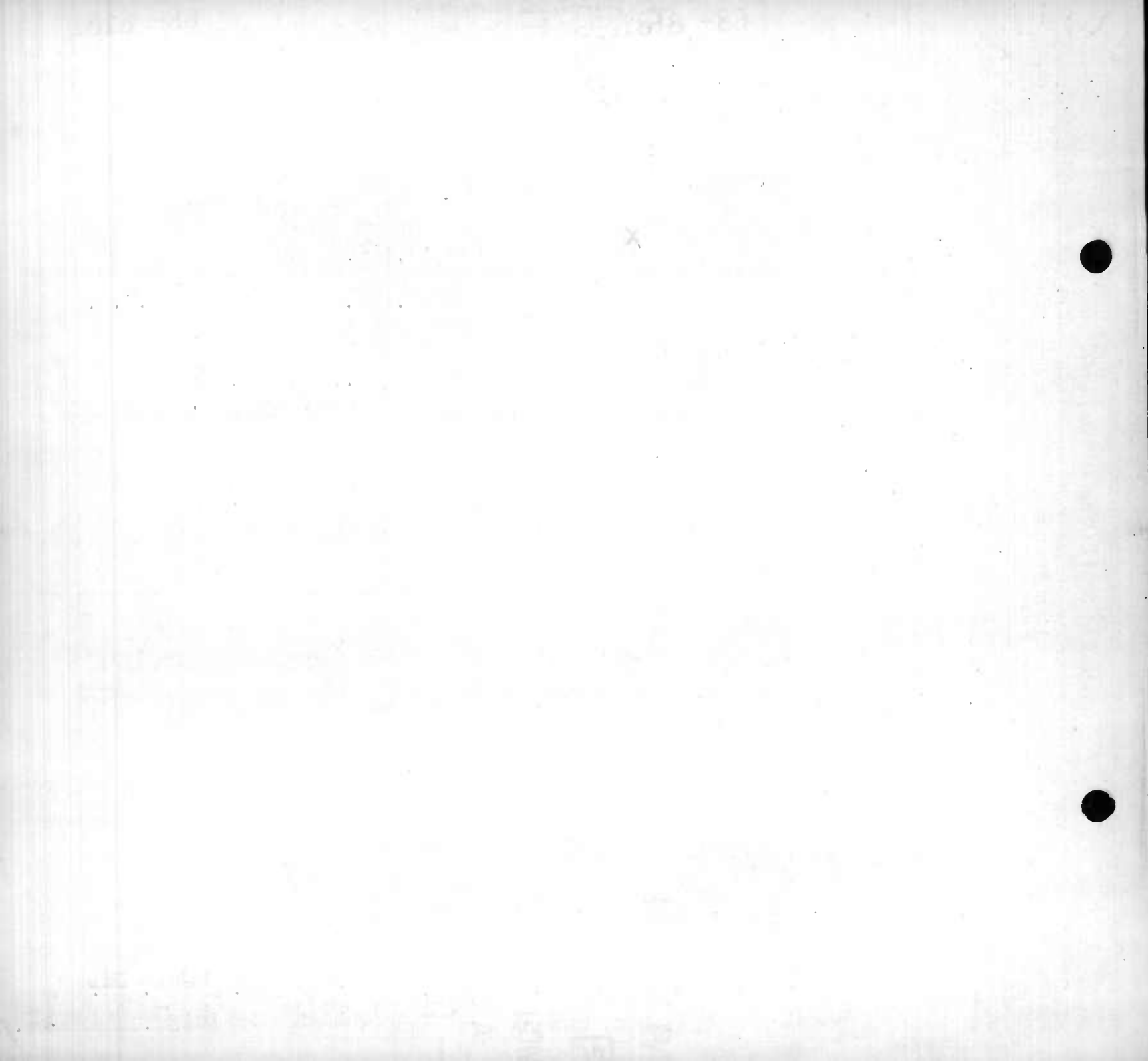
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8181 CERTIFICATE OF DEATH

REG. NO. 68- 8181

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>LILLIAN WOLF</b>		2. DATE AND HOUR OF DEATH <b>August 6, 68 4 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-15</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital of Maryland</b> <b>46</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>4345 Newport Ave</b>					
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 12, 1897</b>	9. AGE (In years lost birth day) <b>71</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Frederick Johnston</b>			14. MOTHER'S MAIDEN NAME <b>Clara ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. James S. Ansell</b> <b>From 803 York Rd. From Nat.</b>	
18. <b>204.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Acute Lymphoid Leukemia</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>204.3 II</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 29 19 68</b> to <b>August 6 19 68</b> , that (I) (we) last saw the deceased alive on <b>August 6 19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>C. S. Ming</b>			23B. DATE SIGNED <b>8/6/68</b>		
23C. PHYSICIAN'S NAME (Type) <b>CHEE SHWE MING</b>			23D. ADDRESS <b>Lutheran Hospital of Maryland.</b>		
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/10/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Taylor Ave. Balto. Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairburn</b>		25C. FUNERAL DIRECTOR ADDRESS <b>KRAUSE FUNERAL HOME 1416 S. Charles St.</b>	



R-152

68- 8182 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 8182

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>FRANCIS X. ROBINSON</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>8 6 68 4:19 p. M.</b>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>42 Sinai Hospital</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 6, 1968 4:19 p. M.</b>			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Sykesville</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				6. SEX <b>Male</b> 7. RACE <b>White</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. DATE OF BIRTH <b>12-21-1921</b> 10. AGE (In years last birthday) <b>46</b> 11. BIRTHPLACE (State or foreign country) <b>Bacto, Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				E. STREET AND NUMBER <b>Sykesville, Box 269</b>			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b> 14B. KIND OF BUSINESS OR INDUSTRY <b>Fisher Body Co</b>				15. MOTHER'S MAIDEN NAME <b>Marie A. Santry</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>YES World War II</b>				17. SOCIAL SECURITY NO. <b>219-01-2660</b>			
18. INFORMANT <b>Wm. Richard D. Robinson</b> ADDRESS <b>8403 Billson Rd</b>				21. AUTOPSY? (Yes or No) <b>YES</b>			
19. <b>E812.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Injuries</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
E816.4 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION <b>2</b> 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>YES</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>			
22D. TIME OF INJURY (APPROX.) <b>8 6 68 1:27pm</b>				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Jones Falls Expressway, 300 ft. S. of Ruxton Rd. overpass</b>				22F. HOW DID INJURY OCCUR? <b>Subject in auto-auto collision</b>			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Edward F. Wilson</b> EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>				DATE SIGNED <b>August 7, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-9-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lake View Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>James Byers</b>		ADDRESS <b>8725 Liberty Road Randallstown, Md</b>	

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12-21-15

George W. Johnson

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James A. Smith

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 68- 8183 CERTIFICATE OF DEATH

REG. NO. 68- 8183

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ROBERT FULTON HUGHES</b>		2. DATE AND HOUR OF DEATH <b>8/9/68 953 P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Harford</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL HOSPITAL</b>			C. CITY OR TOWN <b>FALLSTON</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER <b>2819 HARFORD RD</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 17, 1902</b>	
9. AGE (In years last birthday) <b>66</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Munitions Foreman</b>		11. BIRTHPLACE (State or foreign country) <b>Aberdeen, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Morgan Hughes</b>		14. MOTHER'S MAIDEN NAME <b>Jessie Fulton</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-07-1852</b>		17. INFORMANT (Wife) <b>838-7766</b> <b>Mrs. Helen G. Hughes</b> ADDRESS <b>2819 Harford Road Fallston, Maryland 21047</b>	
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Complete Heart Block</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerosis CVD</b> <b>Coronary Heart failure</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>4 hours</b> <b>5 years</b> <b>1 week</b>		
MEDICAL CERTIFICATION <b>433.0 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/9 1968</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>8/9 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. H. Townsend M.D.</b> DEGREE				23B. DATE SIGNED <b>8/9/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>W. H. TOWNSEND M.D.</b> DEGREE				23D. ADDRESS <b>14 E. Eager St Baltimore M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 12, 1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Grove Presbyterian Ch. Cem.</b>	
24D. LOCATION <b>Aberdeen, Harford Co., Md. 21001</b>		24E. NAME OF REGISTRAR <b>Robert E. Taylor</b>		24F. FUNERAL DIRECTOR <b>Joseph William Foster</b> ADDRESS <b>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

1847

July 17, 1847

1847

James W. Smith

John C. Smith

John C. Smith

1847

James W. Smith

John C. Smith

John C. Smith

James W. Smith, 1847-1848, 1849-1850, 1851-1852, 1853-1854, 1855-1856, 1857-1858, 1859-1860, 1861-1862, 1863-1864, 1865-1866, 1867-1868, 1869-1870, 1871-1872, 1873-1874, 1875-1876, 1877-1878, 1879-1880, 1881-1882, 1883-1884, 1885-1886, 1887-1888, 1889-1890, 1891-1892, 1893-1894, 1895-1896, 1897-1898, 1899-1900, 1901-1902, 1903-1904, 1905-1906, 1907-1908, 1909-1910, 1911-1912, 1913-1914, 1915-1916, 1917-1918, 1919-1920, 1921-1922, 1923-1924, 1925-1926, 1927-1928, 1929-1930, 1931-1932, 1933-1934, 1935-1936, 1937-1938, 1939-1940, 1941-1942, 1943-1944, 1945-1946, 1947-1948, 1949-1950, 1951-1952, 1953-1954, 1955-1956, 1957-1958, 1959-1960, 1961-1962, 1963-1964, 1965-1966, 1967-1968, 1969-1970, 1971-1972, 1973-1974, 1975-1976, 1977-1978, 1979-1980, 1981-1982, 1983-1984, 1985-1986, 1987-1988, 1989-1990, 1991-1992, 1993-1994, 1995-1996, 1997-1998, 1999-2000, 2001-2002, 2003-2004, 2005-2006, 2007-2008, 2009-2010, 2011-2012, 2013-2014, 2015-2016, 2017-2018, 2019-2020, 2021-2022, 2023-2024, 2025-2026, 2027-2028, 2029-2030, 2031-2032, 2033-2034, 2035-2036, 2037-2038, 2039-2040, 2041-2042, 2043-2044, 2045-2046, 2047-2048, 2049-2050, 2051-2052, 2053-2054, 2055-2056, 2057-2058, 2059-2060, 2061-2062, 2063-2064, 2065-2066, 2067-2068, 2069-2070, 2071-2072, 2073-2074, 2075-2076, 2077-2078, 2079-2080, 2081-2082, 2083-2084, 2085-2086, 2087-2088, 2089-2090, 2091-2092, 2093-2094, 2095-2096, 2097-2098, 2099-2100, 2101-2102, 2103-2104, 2105-2106, 2107-2108, 2109-2110, 2111-2112, 2113-2114, 2115-2116, 2117-2118, 2119-2120, 2121-2122, 2123-2124, 2125-2126, 2127-2128, 2129-2130, 2131-2132, 2133-2134, 2135-2136, 2137-2138, 2139-2140, 2141-2142, 2143-2144, 2145-2146, 2147-2148, 2149-2150, 2151-2152, 2153-2154, 2155-2156, 2157-2158, 2159-2160, 2161-2162, 2163-2164, 2165-2166, 2167-2168, 2169-2170, 2171-2172, 2173-2174, 2175-2176, 2177-2178, 2179-2180, 2181-2182, 2183-2184, 2185-2186, 2187-2188, 2189-2190, 2191-2192, 2193-2194, 2195-2196, 2197-2198, 2199-2200, 2201-2202, 2203-2204, 2205-2206, 2207-2208, 2209-2210, 2211-2212, 2213-2214, 2215-2216, 2217-2218, 2219-2220, 2221-2222, 2223-2224, 2225-2226, 2227-2228, 2229-2230, 2231-2232, 2233-2234, 2235-2236, 2237-2238, 2239-2240, 2241-2242, 2243-2244, 2245-2246, 2247-2248, 2249-2250, 2251-2252, 2253-2254, 2255-2256, 2257-2258, 2259-2260, 2261-2262, 2263-2264, 2265-2266, 2267-2268, 2269-2270, 2271-2272, 2273-2274, 2275-2276, 2277-2278, 2279-2280, 2281-2282, 2283-2284, 2285-2286, 2287-2288, 2289-2290, 2291-2292, 2293-2294, 2295-2296, 2297-2298, 2299-2300, 2301-2302, 2303-2304, 2305-2306, 2307-2308, 2309-2310, 2311-2312, 2313-2314, 2315-2316, 2317-2318, 2319-2320, 2321-2322, 2323-2324, 2325-2326, 2327-2328, 2329-2330, 2331-2332, 2333-2334, 2335-2336, 2337-2338, 2339-2340, 2341-2342, 2343-2344, 2345-2346, 2347-2348, 2349-2350, 2351-2352, 2353-2354, 2355-2356, 2357-2358, 2359-2360, 2361-2362, 2363-2364, 2365-2366, 2367-2368, 2369-2370, 2371-2372, 2373-2374, 2375-2376, 2377-2378, 2379-2380, 2381-2382, 2383-2384, 2385-2386, 2387-2388, 2389-2390, 2391-2392, 2393-2394, 2395-2396, 2397-2398, 2399-2400, 2401-2402, 2403-2404, 2405-2406, 2407-2408, 2409-2410, 2411-2412, 2413-2414, 2415-2416, 2417-2418, 2419-2420, 2421-2422, 2423-2424, 2425-2426, 2427-2428, 2429-2430, 2431-2432, 2433-2434, 2435-2436, 2437-2438, 2439-2440, 2441-2442, 2443-2444, 2445-2446, 2447-2448, 2449-2450, 2451-2452, 2453-2454, 2455-2456, 2457-2458, 2459-2460, 2461-2462, 2463-2464, 2465-2466, 2467-2468, 2469-2470, 2471-2472, 2473-2474, 2475-2476, 2477-2478, 2479-2480, 2481-2482, 2483-2484, 2485-2486, 2487-2488, 2489-2490, 2491-2492, 2493-2494, 2495-2496, 2497-2498, 2499-2500, 2501-2502, 2503-2504, 2505-2506, 2507-2508, 2509-2510, 2511-2512, 2513-2514, 2515-2516, 2517-2518, 2519-2520, 2521-2522, 2523-2524, 2525-2526, 2527-2528, 2529-2530, 2531-2532, 2533-2534, 2535-2536, 2537-2538, 2539-2540, 2541-2542, 2543-2544, 2545-2546, 2547-2548, 2549-2550, 2551-2552, 2553-2554, 2555-2556, 2557-2558, 2559-2560, 2561-2562, 2563-2564, 2565-2566, 2567-2568, 2569-2570, 2571-2572, 2573-2574, 2575-2576, 2577-2578, 2579-2580, 2581-2582, 2583-2584, 2585-2586, 2587-2588, 2589-2590, 2591-2592, 2593-2594, 2595-2596, 2597-2598, 2599-2600, 2601-2602, 2603-2604, 2605-2606, 2607-2608, 2609-2610, 2611-2612, 2613-2614, 2615-2616, 2617-2618, 2619-2620, 2621-2622, 2623-2624, 2625-2626, 2627-2628, 2629-2630, 2631-2632, 2633-2634, 2635-2636, 2637-2638, 2639-2640, 2641-2642, 2643-2644, 2645-2646, 2647-2648, 2649-2650, 2651-2652, 2653-2654, 2655-2656, 2657-2658, 2659-2660, 2661-2662, 2663-2664, 2665-2666, 2667-2668, 2669-2670, 2671-2672, 2673-2674, 2675-2676, 2677-2678, 2679-2680, 2681-2682, 2683-2684, 2685-2686, 2687-2688, 2689-2690, 2691-2692, 2693-2694, 2695-2696, 2697-2698, 2699-2700, 2701-2702, 2703-2704, 2705-2706, 2707-2708, 2709-2710, 2711-2712, 2713-2714, 2715-2716, 2717-2718, 2719-2720, 2721-2722, 2723-2724, 2725-2726, 2727-2728, 2729-2730, 2731-2732, 2733-2734, 2735-2736, 2737-2738, 2739-2740, 2741-2742, 2743-2744, 2745-2746, 2747-2748, 2749-2750, 2751-2752, 2753-2754, 2755-2756, 2757-2758, 2759-2760, 2761-2762, 2763-2764, 2765-2766, 2767-2768, 2769-2770, 2771-2772, 2773-2774, 2775-2776, 2777-2778, 2779-2780, 2781-2782, 2783-2784, 2785-2786, 2787-2788, 2789-2790, 2791-2792, 2793-2794, 2795-2796, 2797-2798, 2799-2800, 2801-2802, 2803-2804, 2805-2806, 2807-2808, 2809-2810, 2811-2812, 2813-2814, 2815-2816, 2817-2818, 2819-2820, 2821-2822, 2823-2824, 2825-2826, 2827-2828, 2829-2830, 2831-2832, 2833-2834, 2835-2836, 2837-2838, 2839-2840, 2841-2842, 2843-2844, 2845-2846, 2847-2848, 2849-2850, 2851-2852, 2853-2854, 2855-2856, 2857-2858, 2859-2860, 2861-2862, 2863-2864, 2865-2866, 2867-2868, 2869-2870, 2871-2872, 2873-2874, 2875-2876, 2877-2878, 2879-2880, 2881-2882, 2883-2884, 2885-2886, 2887-2888, 2889-2890, 2891-2892, 2893-2894, 2895-2896, 2897-2898, 2899-2900, 2901-2902, 2903-2904, 2905-2906, 2907-2908, 2909-2910, 2911-2912, 2913-2914, 2915-2916, 2917-2918, 2919-2920, 2921-2922, 2923-2924, 2925-2926, 2927-2928, 2929-2930, 2931-2932, 2933-2934, 2935-2936, 2937-2938, 2939-2940, 2941-2942, 2943-2944, 2945-2946, 2947-2948, 2949-2950, 2951-2952, 2953-2954, 2955-2956, 2957-2958, 2959-2960, 2961-2962, 2963-2964, 2965-2966, 2967-2968, 2969-2970, 2971-2972, 2973-2974, 2975-2976, 2977-2978, 2979-2980, 2981-2982, 2983-2984, 2985-2986, 2987-2988, 2989-2990, 2991-2992, 2993-2994, 2995-2996, 2997-2998, 2999-3000, 3001-3002, 3003-3004, 3005-3006, 3007-3008, 3009-3010, 3011-3012, 3013-3014, 3015-3016, 3017-3018, 3019-3020, 3021-3022, 3023-3024, 3025-3026, 3027-3028, 3029-3030, 3031-3032, 3033-3034, 3035-3036, 3037-3038, 3039-3040, 3041-3042, 3043-3044, 3045-3046, 3047-3048, 3049-3050, 3051-3052, 3053-3054, 3055-3056, 3057-3058, 3059-3060, 3061-3062, 3063-3064, 3065-3066, 3067-3068, 3069-3070, 3071-3072, 3073-3074, 3075-3076, 3077-3078, 3079-3080, 3081-3082, 3083-3084, 3085-3086, 3087-3088, 3089-3090, 3091-3092, 3093-3094, 3095-3096, 3097-3098, 3099-3100, 3101-3102, 3103-3104, 3105-3106, 3107-3108, 3109-3110, 3111-3112, 3113-3114, 3115-3116, 3117-3118, 3119-3120, 3121-3122, 3123-3124, 3125-3126, 3127-3128, 3129-3130, 3131-3132, 3133-3134, 3135-3136, 3137-3138, 3139-3140, 3141-3142, 3143-3144, 3145-3146, 3147-3148, 3149-3150, 3151-3152, 3153-3154, 3155-3156, 3157-3158, 3159-3160, 3161-3162, 3163-3164, 3165-3166, 3167-3168, 3169-3170, 3171-3172, 3173-3174, 3175-3176, 3177-3178, 3179-3180, 3181-3182, 3183-3184, 3185-3186, 3187-3188, 3189-3190, 3191-3192, 3193-3194, 3195-3196, 3197-3198, 3199-3200, 3201-3202, 3203-3204, 3205-3206, 3207-3208, 3209-3210, 3211-3212, 3213-3214, 3215-3216, 3217-3218, 3219-3220, 3221-3222, 3223-3224, 3225-3226, 3227-3228, 3229-3230, 3231-3232, 3233-3234, 3235-3236, 3237-3238, 3239-3240, 3241-3242, 3243-3244, 3245-3246, 3247-3248, 3249-3250, 3251-3252, 3253-3254, 3255-3256, 3257-3258, 3259-3260, 3261-3262, 3263-3264, 3265-3266, 3267-3268, 3269-3270, 3271-3272, 3273-3274, 3275-3276, 3277-3278, 3279-3280, 3281-3282, 3283-3284, 3285-3286, 3287-3288, 3289-3290, 3291-3292, 3293-3294, 3295-3296, 3297-3298, 3299-3300, 3301-3302, 3303-3304, 3305-3306, 3307-3308, 3309-3310, 3311-3312, 3313-3314, 3315-3316, 3317-3318, 3319-3320, 3321-3322, 3323-3324, 3325-3326, 3327-3328, 3329-3330, 3331-3332, 3333-3334, 3335-3336, 3337-3338, 3339-3340, 3341-3342, 3343-3344, 3345-3346, 3347-3348, 3349-3350, 3351-3352, 3353-3354, 3355-3356, 3357-3358, 3359-3360, 3361-3362, 3363-3364, 3365-3366, 3367-3368, 3369-3370, 3371-3372, 3373-3374, 3375-3376, 3377-3378, 3379-3380, 3381-3382, 3383-3384, 3385-3386, 3387-3388, 3389-3390, 3391-3392, 3393-3394, 3395-3396, 3397-3398, 3399-3400, 3401-3402, 3403-3404, 3405-3406, 3407-3408, 3409-3410, 3411-3412, 3413-3414, 3415-3416, 3417-3418, 3419-3420, 3421-3422, 3423-3424, 3425-3426, 3427-3428, 3429-3430, 3431-3432, 3433-3434, 3435-3436, 3437-3438, 3439-3440, 3441-3442, 3443-3444, 3445-3446, 3447-3448, 3449-3450, 3451-3452, 3453-3454, 3455-3456, 3457-3458, 3459-3460, 3461-3462, 3463-3464, 3465-3466, 3467-3468, 3469-3470, 3471-3472, 3473-3474, 3475-3476, 3477-3478, 3479-3480, 3481-3482, 3483-3484, 3485-3486, 3487-3488, 3489-3490, 3491-3492, 3493-3494, 3495-3496, 3497-3498, 3499-3500, 3501-3502, 3503-3504, 3505-3506, 3507-3508, 3509-3510, 3511-3512, 3513-3514, 3515-3516, 3517-3518, 3519-3520, 3521-3522, 3523-3524, 3525-3526, 3527-3528, 3529-3530, 3531-3532, 3533-3534, 3535-3536, 3537-3538, 3539-3540, 3541-3542, 3543-3544, 3545-3546, 3547-3548, 3549-3550, 3551-3552, 3553-3554, 3555-3556, 3557-3558, 3559-3560, 3561-3562, 3563-3564, 3565-3566, 3567-3568, 3569-3570, 3571-3572, 3573-3574, 3575-3576, 3577-3578, 3579-3580, 3581-3582, 3583-3584, 3585-3586, 3587-3588, 3589-3590, 3591-3592, 3593-3594, 3595-3596, 3597-3598, 3599-3600, 3601-3602, 3603-3604, 3605-3606, 3607-3608, 3609-3610, 3611-3612, 3613-3614, 3615-3616, 3617-3618, 3619-3620, 3621-3622, 3623-3624, 3625-3626, 3627-3628, 3629-3630, 3631-3632, 3633-3634, 3635-3636, 3637-3638, 3639-3640, 3641-3642, 3643-3644, 3645-3646, 3647-3648, 3649-3650, 3651-3652, 3653-3654, 3655-3656, 3657-3658, 3659-3660, 3661-3662, 3663-3664, 3665-3666, 3667-3668, 3669-3670, 3671-3672, 3673-3674, 3675-3676, 3677-3678, 3679-3680, 3681-3682, 3683-3684, 3685-3686, 3687-3688, 3689-3690, 3691-3692, 3693-3694, 3695-3696, 3697-3698, 3699-3700, 3701-3702, 3703-3704, 3705-3706, 3707-3708, 3709-3710, 3711-3712, 3713-3714, 3715-3716, 3717-3718, 3719-3720, 3721-3722, 3723-3724, 3725-3726, 3727-3728, 3729-3730, 3731-3732, 3733-3734, 3735-3736, 3737-3738, 3739-3740, 3741-3742, 3743-3744, 3745-3746, 3747-3748, 3749-3750, 3751-3752, 3753-3754, 3755-3756, 3757-3758, 3759-3760, 3761-3762, 3763-3764, 3765-3766, 3767-3768, 3769-3770, 3771-3772, 3773-3774, 3775-3776, 3777-3778, 3779-3780, 3781-3782, 3783-3784, 3785-3786, 3787-3788, 3789-3790, 3791-3792, 3793-3794, 3795-3796, 3797-3798, 3799-3800, 3801-3802, 3803-3804, 3805-3806, 3807-3808, 3809-3810, 3811-3812, 3813-3814, 3815-3816, 3817-3818, 3819-3820, 3821-3822, 3823-3824, 3825-3826, 3827-3828, 3829-3830, 3831-3832, 3833-3834, 3835-3836, 3837-3838, 3839-3840, 3841-3842, 3843-3844, 3845-3846, 3847-3848, 3849-3850, 3851-3852, 3853-3854, 3855-3856, 3857-3858, 3859-3860, 3861-3862, 3863-3864, 3865-3866, 3867-3868, 3869-3870, 3871-3872, 3873-3874, 3875-3876, 3877-3878, 3879-3880, 3881-3882, 3883-3884, 3885-3886, 3887-3888, 3889-3890, 3891-3892, 3893-3894, 3895-3896, 3897-3898, 3899-3900, 3901-3902, 3903-3904, 3905-3906, 3907-3908, 3909-3910, 3911-3912, 3913-3914, 3915-3916, 3917-3918, 3919-3920, 3921-3922, 3923-3924, 3925-3926, 3927-3928, 3929-3930, 3931-3932, 3933-3934, 3935-3936, 3937-3938, 3939-3940, 3941-3942, 3943-3944, 3945-3946, 3947-3948, 3949-3950, 3951-3952, 3953-3954, 3955-3956, 3957-3958, 3959-3960, 3961-3962, 3963-3964, 3965-3966, 3967-3968, 3969-3970, 3971-3972, 3973-3974, 3975-3976, 3977-3978, 3979-3980, 3981-3982, 3983-3984, 3985-3986, 3987-3988, 3989-3990, 3991-3992, 3993-3994, 3995-3996, 3997-3998, 3999-4000, 4001-4002, 4003-4004, 4005-4006, 4007-4008, 4009-4010, 4011-4012, 4013-4014, 4015-4016, 4017-4018, 4019-4020, 4021-4022, 4023-402

52-34-66 LB

T-620

68- 8184

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

68- 8184

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

BENNETT TRACY

2. DATE AND HOUR OF DEATH

8-7-68

1:45 P.M. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

31

BALTIMORE CITY HOSPITALS

4940 EASTERN AVENUE

BALTIMORE, MARYLAND 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

512 N. EAST STREET 21202 007

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

4-12-99

9. AGE (In years  
last birthday)

69

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

GUARD- Ret.

10B. KIND OF BUSINESS OR INDUSTRY

MD. PENITENTARY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

EUGENE (DEC.)

14. MOTHER'S MAIDEN NAME

MARY GARICK (DEC.)

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown)

YES

(If yes, give war or dates of service)

1916-1919

16. SOCIAL  
SECURITY NO.

214-20-4052

17. INFORMANT ADDRESS

RECORDS: BALTIMORE CITY HOSPITALS

4940 EASTERN AVE., BALTO., MD. 21224

18.

199.0 I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

DISSEM. CA + CV  
failure

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

199.2 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/6 19 68 to 8/7 19 68,  
that (I) (we) lost saw the deceased alive on 8/7 19 68 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Stewart Leibowitz M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

8-7-68

23C. PHYSICIAN'S  
NAME (Type)

STEWART LEIBOWITZ, M.D.

DEGREE

23D. ADDRESS

BALTIMORE CITY HOSPITALS

4940 EASTERN AVE., BALTO., MD. 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

AUG. 10, 1968

24C. NAME OF CEMETERY or CREMATORY

DULANEY VALLEY MEMORIAL

24D. LOCATION

(City, town, or county)

(State)

COCKEYSVILLE MD.

25A. DATE RECEIVED BY HEALTH DEPT.

AUG 12 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

John Burns' Sons, Towson Md.

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

Diogen. Ch + (V)  
further

8/12 20

8/12

12/1

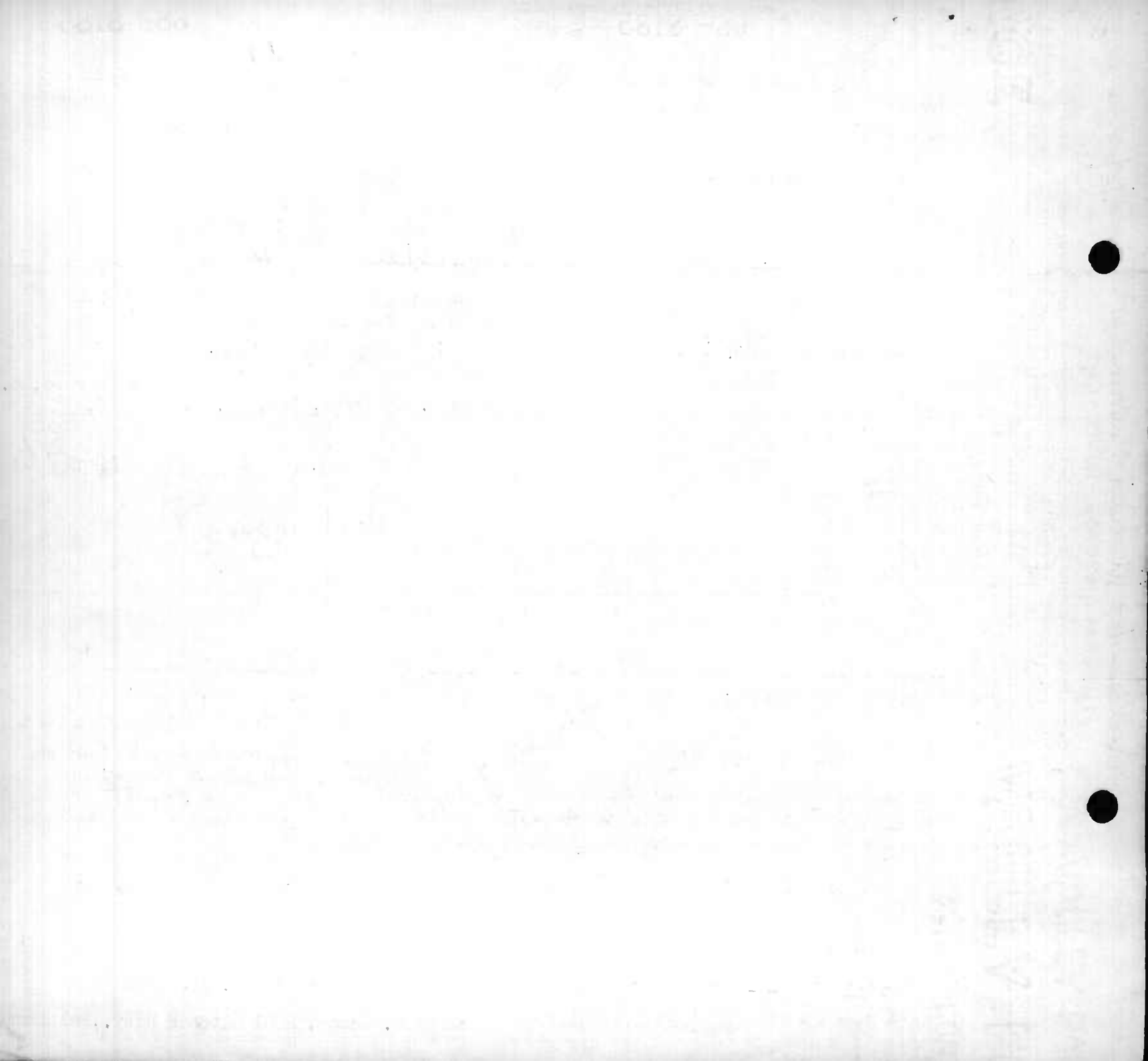
Stewart (Lindsey A)

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 8185 CERTIFICATE OF DEATH

REG. NO. 68- 8185

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Mac Isaac, John A., Jr. IV</b>		2. DATE AND HOUR OF DEATH <b>6 August '68 9:20 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel</b> <b>52-00</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>University of Maryland Hospital</b> <b>38</b>			C. CITY OR TOWN <b>Glen Burnie</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER <b>Rt 1 Box 245</b>					
5. SEX <b>M</b>	6. RACE <b>Can</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/23/55</b>	9. AGE (In years last birthday) <b>12</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>John A. MacIsaac III</b>			14. MOTHER'S MAIDEN NAME <b>Patricia McColgan</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>John A. MacIsaac, 3rd, Rt. 1, Box 245,</b> ADDRESS <b>Glen Burnie, Md.</b>		
18. <b>E 910.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>E 929.4 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <b>2</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <b>yes</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			CAUSE OF DEATH <b>Drowning +</b> <b>Head injury</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>16-17 hrs</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) <b>Beach</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Anne Arundel Co. 52-00</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>Aug 5 1968 4:30 PM</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fell from diving board, struck head on platform + then fell into the water.</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>5 August 1968</b> to <b>6 August 1968</b> and that (I) (we) lost saw the deceased alive on <b>6 August 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Marston A Young MD</b>			23B. DATE SIGNED <b>6 Aug 68</b>		23C. PHYSICIAN'S NAME (Type) <b>Marston A Young MD</b>
23D. ADDRESS <b>Baltimore National Cemetery</b>			23E. ADDRESS <b>Baltimore, Maryland</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-9-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, MD</b>	
25C. FUNERAL DIRECTOR <b>George J. Gonze, 4001 Ritchie Hwy., Baltimore</b>		25D. ADDRESS <b>Baltimore, Maryland</b>			



P-620

68- 8186 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8186

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CHARLES PIERCE</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>August 8, 1968</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4715 Ivanhoe Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 8, 1968 8:30 A. M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>July 24, 1895</b>		10. AGE (In years lost birthday) <b>73</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		15. MOTHER'S MAIDEN NAME <b>Della Fernell</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>218-10-1179</b>	
18. INFORMANT <b>Mrs. Bernadine Johnson</b>		ADDRESS <b>4715 Ivanhoe Ave.</b>	
19. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <b>August 8, 1968</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug 11, 1968</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Brooklyn Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>	
25C. FUNERAL DIRECTOR <b>Joseph R. Russ</b>		ADDRESS <b>2222 W. North Ave. Baltimore Md</b>	

Shirley A. Brown  
Superintendent

James Brown  
Public Health

See me for the [unclear] from the [unclear]

WALLIS

125/0714

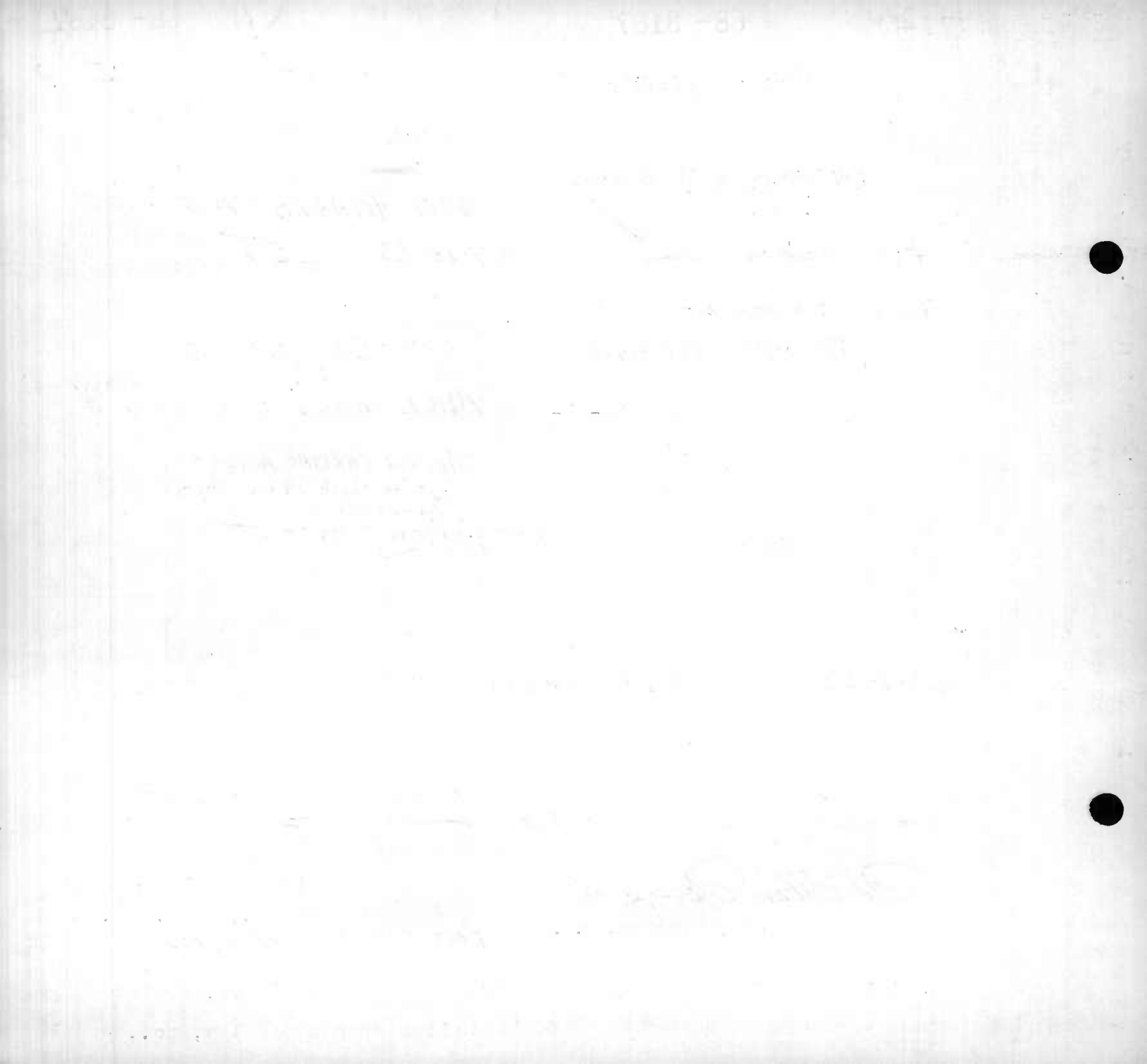
Class 7-12

James Brown  
Public Health

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.		68- 8187	
BIRTH NO.				68- 8187			
1. NAME OF DECEASED (Type or Print) <b>HEGGIE, HARVEY F. SR.</b>				2. DATE AND HOUR OF DEATH <b>8-9-68</b> <b>715 P.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVE.</b> <b>31</b> <b>BA:TO., MD. 21224</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b> 6. RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>7-16-13</b>		9. AGE (In years lost birthday) <b>55</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SERVICE STATION ATTENDANT</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>THOMAS HEGGIE</b>			
14. MOTHER'S MAIDEN NAME <b>WOOTEN, BESSIE</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>224-01-1295</b>				17. INFORMANT BCH: <b>4940 EASTERN AVE BALTO., MD. 21224</b> <b>ALICE HEGGIE (WIFE) #4 E.</b>			
18. <b>441.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>SHOCK &amp; CARDIAC ARREST</b> <b>due to Ruptured Abdominal Aortic Aneurysm -</b> <b>Respiratory Arrest</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. <b>451X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>8-9-68</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ruptured Aneurysm</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(I)</del> (this hospital) attended the deceased from <b>8-9-68</b> 19 to <b>8-9-68</b> 19 that <del>(I)</del> (we) last saw the deceased alive on <b>8-9-68</b> 19 and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Peter William Ross Jr. M.D.</b>				23B. DATE SIGNED <b>8-9-68</b>			
23C. PHYSICIAN'S NAME (Type) <b>PETER WILLIAM ROSS JR. M.D.</b>				23D. ADDRESS <b>4940 EASTERN AVE., BALTO., MD. 21224</b> <b>BALT CITY HOSP, BALT, MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>8/12/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith</b>	
24D. LOCATION <b>Baltimore, Maryland</b>							
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>		25C. FUNERAL DIRECTOR <b>Walter Brooks Bradley, Inc., Dundalk</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## 68- 8188 CERTIFICATE OF DEATH

REG. NO.

68- 8188

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Frederick Morgenroth</b>		2. DATE AND HOUR OF DEATH <b>Aug. 7-1968</b>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>Gould's Nursing Home</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balto. Co</b>		53-00	
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>8313 Philadelphia Rd.</b>			
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-16-93</b>	
				9. AGE (In years last birthday) <b>74</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipefitter retired</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Frederick Morgenroth</b>				14. MOTHER'S MAIDEN NAME <b>Cornelia Hahn</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-07-0357</b>		17. INFORMANT <b>Matilida Morgenroth</b>	
				ADDRESS <b>8313 Phila Rd</b>			
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>C.V.A.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic Cardiac Vascular Disease 10 yrs</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. <b>422.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 1 1968</b> to <b>Aug 7 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 7 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>G. M. Baumgardner</b>				23B. DATE SIGNED <b>8/9/68</b>			
23C. PHYSICIAN'S NAME (Type) <b>G. M. Baumgardner</b>				23D. ADDRESS <b>Balto 21237</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>8-10-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Greenmount Crematory</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Lassahn Funeral Home</b>		ADDRESS <b>7401 Belair 21236</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8189

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CHESTER MITCHELL</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>August 7, 1968</b>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital (DOA)</b>				3. DATE PRONOUNCED DEAD Month Day Year <b>August 7, 1968</b> 2:50 P.M.			
6. SEX <b>Male</b>				7. RACE <b>White</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>8-11-14</b>				10. AGE (In years last birthday) <b>53</b>		11. BIRTHPLACE (State or foreign country) <b>PENNA</b>	
12. CITIZEN OF <b>USA</b>				13. FATHER'S NAME <b>?</b>			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Warehouseman</b>				15. MOTHER'S MAIDEN NAME <b>Food Fans</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				17. SOCIAL SECURITY NO. <b>---</b>		18. INFORMANT <b>Mrs Mae Mitchell - above</b>	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>				CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>422.1</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>8/10/68</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>August 8, 1968</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL OR CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>8/10/68</b>		<b>Cedar Hill</b>		<b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. GENERAL DIRECTOR		ADDRESS	
<b>AUG 12 1968</b>		<b>Robert E. Farley</b>		<b>John A. Fahn</b>		<b>James H. Hays</b>	

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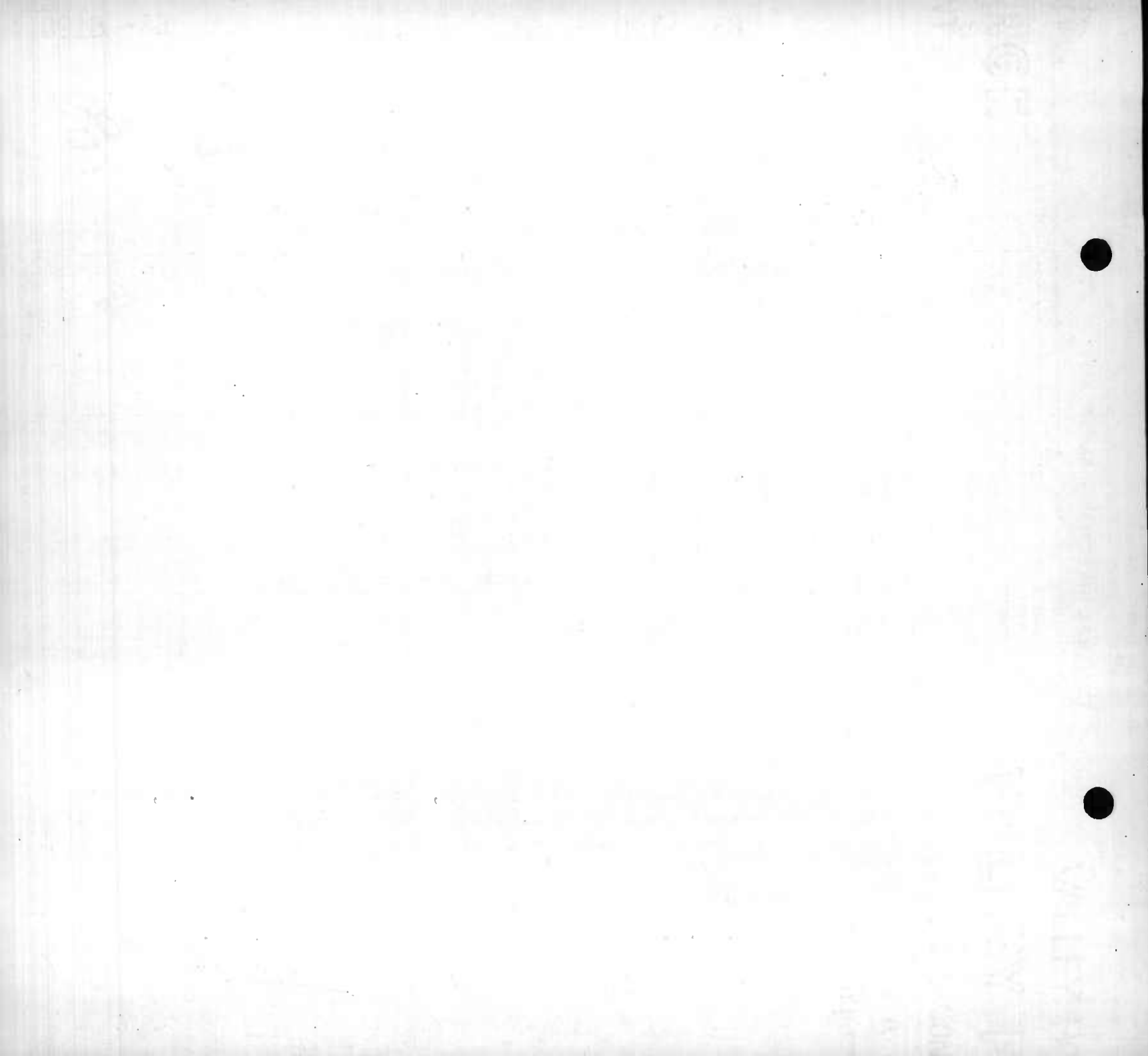
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 68- 8190 CERTIFICATE OF DEATH

REG. NO. 68- 8190

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>MARY PARADA</u>		2. DATE AND HOUR OF DEATH <u>8-7-68</u>		M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> 8. COUNTY <u>25-05</u>					
FULL NAME OF HOSPITAL OR INSTITUTION <u>1609 Locust St.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>1609 Locust St.</u>		5. SEX <u>FEMALE</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>@ home</u>		8. DATE OF BIRTH <u>11-11-1906</u>		9. AGE (In years last birthday) <u>67</u>			
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Anton Parada</u>		ADDRESS <u>Above</u>			
18. <u>25-0-91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arterio-sclerotic heart disease</u> (B) <u>Diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Mental deterioration</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>260X II</u>									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <u>June 3, 1968</u> 19 to <u>Aug. 7, 1968</u> 19, that (I) ( <del>we</del> ) last saw the deceased alive on <u>August 1, 1968</u> 19 and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <u>Samuel Rubin</u>				23B. DATE SIGNED <u>8/8/68</u>		23C. PHYSICIAN'S NAME (Type) <u>Samuel Rubin, M.D.</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <u>8/10/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cedar Hill Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Beth Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 12 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Finkbeiner</u>		25C. FUNERAL DIRECTOR <u>John H. Hahn</u>		ADDRESS <u>Samuel Home</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8191 BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 8191

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>William Diggs Sr</b>		2. DATE AND HOUR OF DEATH <b>8/9 10:55 pm</b>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/9/93</b>	
9. AGE (In years last birthday) <b>75</b>		10. UNDER 1 Yr. Months: Days		11. UNDER 24 Hrs. Hours: Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Captain on Boat</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>VA.</b>	
13. FATHER'S NAME <b>William L. Diggs</b>				14. MOTHER'S MAIDEN NAME <b>Lucy Phillips</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Johanna M. Diggs</b> ADDRESS <b>1228 Battery Av</b>	
18. <b>410.91</b>		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial infarct</b>		<b>2 days</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Coronary insufficiency</b>		<b>5 yrs.</b>		<b>10 yrs.</b>	
(C) <b>ASCVD</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<b>420.1 II</b>			
19A. DATE OF OPERATION <b>8</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>7-25 1968</b> to <b>8-9 1968</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>August 9 1968</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <del>(did not)</del> view the body after death.							
23A. SIGNATURE <b>Sidney R. Gellert MD</b>				23B. DATE SIGNED <b>8/9/68</b>		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS				23E. NAME OF REGISTRAR <b>Robert E. Jenkins</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8 12 68</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>Mc Cully</b>		ADDRESS <b>130 E. Fort Av</b>	



FUNERAL DIRECTOR: IMPORTANT

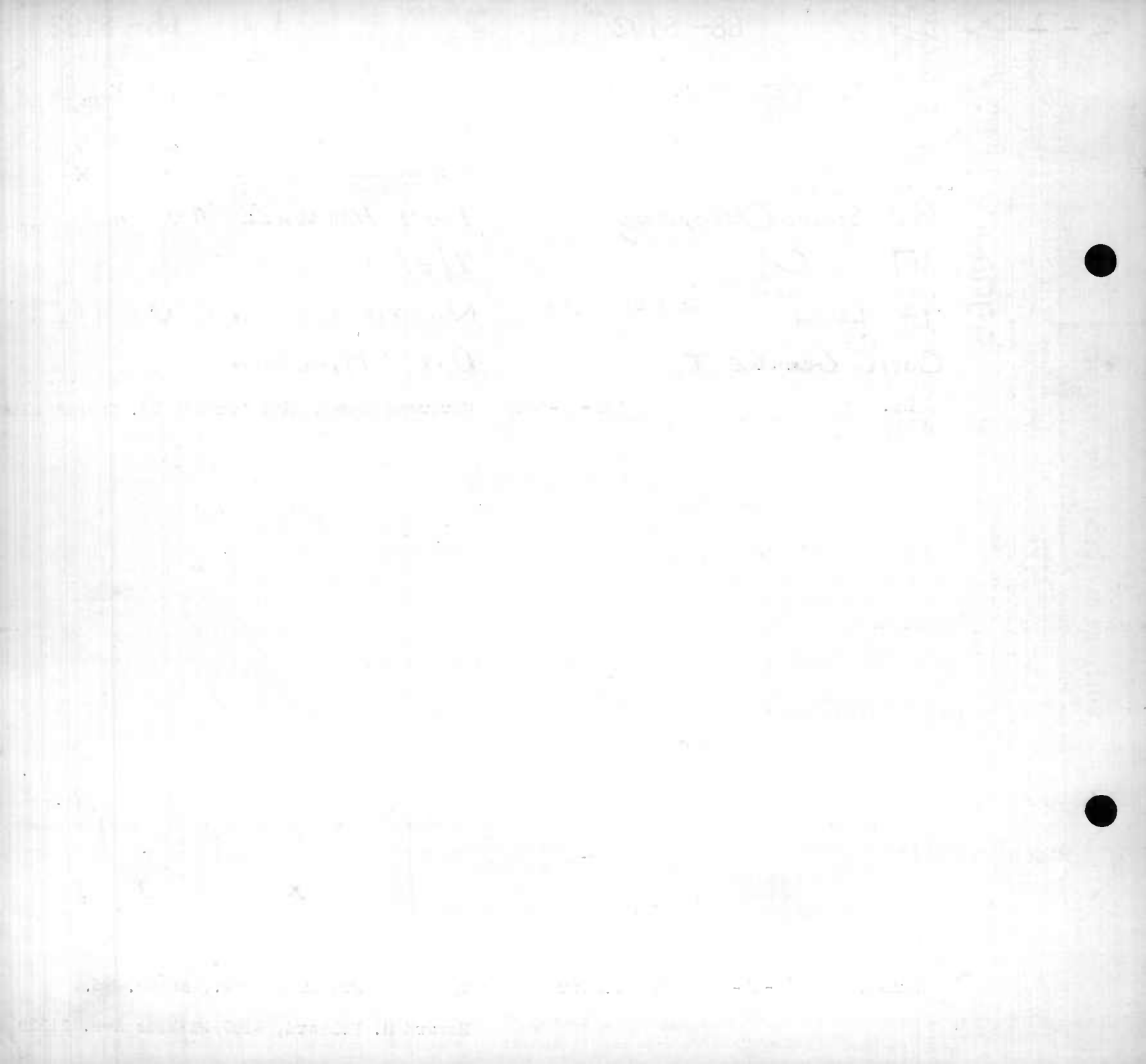
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8192 CERTIFICATE OF DEATH

REG. NO.

68- 8192

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>COOKE, M.R. CHARLES</u>		2. DATE AND HOUR OF DEATH <u>5PM - 8 Aug 1968</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Baltimore</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>34 Bon Secour Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1107 Harwall Rd #7</u>		C. CITY OR TOWN <u>Catonsville</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>7/3/03</u>		9. AGE (In years last birthday) <u>65</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>	
11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Koppers Company</u>	
13. FATHER'S NAME <u>COOK GEORGE T</u>		14. MOTHER'S MAIDEN NAME <u>DIX, MARTHA</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.	
16. SOCIAL SECURITY NO. <u>223-01-0846</u>		17. INFORMANT <u>Gertrude Cooke, 1107 Harwall Rd. Catonsville</u> ADDRESS <u>21207</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>162.1 I</u>		CAUSE OF DEATH <u>Cardiopulmonary failure</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Bilateral Co. of the lung</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>163X II</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8-8-68</u> to <u>8-8-68</u> , that (I) (we) last saw the deceased alive on <u>8-8-68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John T. Yaph...</u>		23B. DATE SIGNED <u>8-8-68</u>		23C. PHYSICIAN'S NAME (Type) <u>John T. Yaph...</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-12-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION <u>Frederick Ave., Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 12 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Sch...</u>	
25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>		25D. ADDRESS			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8193

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MARTHA ALICE MCGLOTHLIN</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 5, 1968 Hour 12:15 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour August 5, 1968 12:15 P.M.	
6. SEX <b>female</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Sept. 24, 1903</b>		10. AGE (In years lost birthday) <b>64</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
15. MOTHER'S MAIDEN NAME <b>Lavie Virginia Belle Hite</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Family</b>	
19. <b>412.2</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>443 X II</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Same</b>	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>22E. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> EXAMINER'S NAME (Type) DATE SIGNED <b>8/6/68</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8 8 68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Hite Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Abingdon, Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, Jr.</b>	
25C. FUNERAL DIRECTOR <b>Mc Cully F. H.</b>		ADDRESS <b>237 Pat. Ave. 21225</b>	

3012

3013

8

11/11/11

11/11/11

James M. Lee

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 8194
<div style="display: flex; justify-content: space-between;"> <span>68- 8194</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Oliver P. Garrett Jr. OLIVER P. GARRETT</b>		2. DATE AND HOUR OF DEATH <b>August 8 18:15 A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH HOME AND HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore Co</b> <b>53-00</b>		
			C. CITY OR TOWN <b>Middle River</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER <b>40 BEECH DR. APT. A2 (20)</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 26 02</b>	9. AGE (In years lost birthday) <b>65</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHIPFITTER 1ST CLASS BETH.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel</b>		11. BIRTHPLACE (State or foreign country) <b>PENNA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>AMER.</b>		13. FATHER'S NAME <b>OLIVER P. GARRETT Sr.</b>		14. MOTHER'S MAIDEN NAME <b>LILA OWENS</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213070929</b>		17. INFORMANT (Wife) <b>Angela Garrett</b> ADDRESS <b>40 Beech Dr. Middle River, Md.</b>	
<div style="display: flex;"> <div style="writing-mode: vertical-rl; transform: rotate(180deg); font-weight: bold; margin-right: 5px;">MEDICAL CERTIFICATION</div> <div> <div> <b>18. 199.0 I</b>  <b>CAUSE OF DEATH</b>  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b>  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. </div> <div> <b>(A) IMMEDIATE CAUSE</b> <u>Metastatic Carcinoma ??</u>  DUE TO, OR AS A CONSEQUENCE OF:  <b>(B)</b> _____  DUE TO, OR AS A CONSEQUENCE OF:  <b>(C)</b> _____ </div> </div> <div> <b>19. 199.2 II</b>  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  <u>Thrombophlebitis, Pneumonia</u> </div> </div>					

1918-1919

RECEIVED

RECEIVED  
BAPTIST

CHURCH HOME AND HOSPITAL

40 GREEN ST. BOSTON (20)

28 25 25 2

W M

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SHUTTLEWORTH

LILA DUNN

OLIVER F. GARRETT

RECEIVED

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 68- 8195 CERTIFICATE OF DEATH

REG. NO. 68- 8195

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HARE JAMES O.</b>		2. DATE AND HOUR OF DEATH <b>8. 8. 1968 9-50 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1-01</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME AND HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>2919 O'DONNELL ST 24.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-11-12</b>	9. AGE (In years last birthday) <b>56</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JOHN HERRY HARE</b>			
14. MOTHER'S MAIDEN NAME <b>HARRIET R</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>216-01-4661</b>		17. INFORMANT ADDRESS <b>WIFE. 2919 O'Donnell St 24.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>410.91</b> <b>Acute myocardial infarction with arrhythmia</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>420.1 II</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiogenic shock, cerebral damage due to anemia.</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) <b>Cardiogenic shock, cerebral damage due to anemia.</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8. 8. 1968</b> to <b>8. 8. 1968</b> , that (I) (we) last saw the deceased alive on <b>8. 8. 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Mesbahud Dowla</b>				23B. DATE SIGNED <b>8. 8. 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>MESBAHUD DOWLA . MD</b>				23D. ADDRESS <b>CHURCH HOME AND HOSPITAL.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-12-68</b>		24C. NAME of CEMETERY or CREMATORY <b>London Pk.</b>	
24D. LOCATION <b>Balto. Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		24F. NAME OF REGISTRAR <b>Robert E. Tarkenton</b>	
24G. FUNERAL DIRECTOR <b>Thelma A. Hoffmann</b>		24H. ADDRESS <b>3218 Hudson St</b>			

CHURCH HOME AND HOSPITAL

BOY O. Danner - 25 24

1-11-12 25

and

HARRIST &

WIFE - 25 19 O. Danner 11 24

Good representative  
of the best of the  
community

Chapman Street - 2nd floor

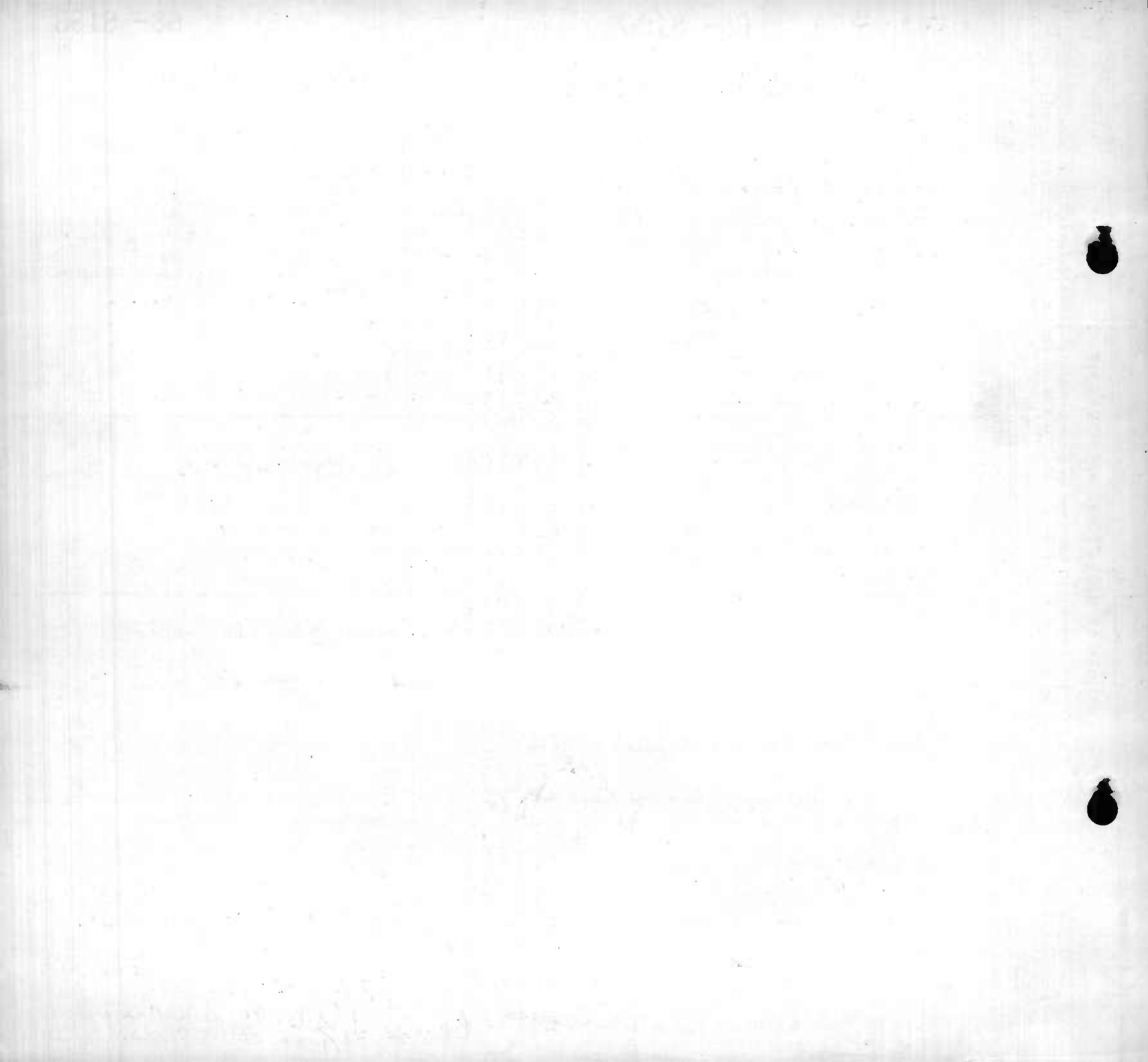
John Henry Hare

Continued

Residence - 1000 - 1000 - 1000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-152		68- 8196		CERTIFICATE OF DEATH		REG. NO. 68- 8196	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>Henry H. Hofmeister</b>			
2. DATE AND HOUR OF DEATH <b>8/8/68 8<sup>30</sup> PM.</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>601 NORTH BROADWAY, BALTIMORE, MARYLAND</b>				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>3927 EAST LOMBARD STREET 21224</b>				5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>4-26-1908</b>				9. AGE (In years last birthday) <b>60</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>BAINBRIDGE CO.</b>			
11. BIRTHPLACE (State or foreign country) <b>MARYLAND, BALTIMORE</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John HOFMEISTER</b>				14. MOTHER'S MAIDEN NAME <b>MAGDALENA JOHNSON</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>220-05-5303</b>			
17. INFORMANT <b>RECORDS: BCH-4940 EASTERN AVENUE</b>				ADDRESS <b>21224</b>			
18. <b>450X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary embolus</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. <b>465X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>heart failure, ASCVD</b>							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>July 8 1968</b> to <b>July 8 1968</b> , that (I) (we) last saw the deceased alive on <b>July 8 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Carole Dorsch</b>				23B. DATE SIGNED <b>8/8/68</b>		23C. PHYSICIAN'S NAME (Type) <b>CAROLE DORSCH</b>	
23D. ADDRESS <b>601 NORTH BROADWAY, BALTIMORE, MD.</b>				23E. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		23F. FUNERAL DIRECTOR <b>Charles S. J. Miller</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-12-68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. CO. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>Charles S. J. Miller</b>		25D. ADDRESS <b>901 S. CONKLING ST. BALTO. 21224, MD.</b>	



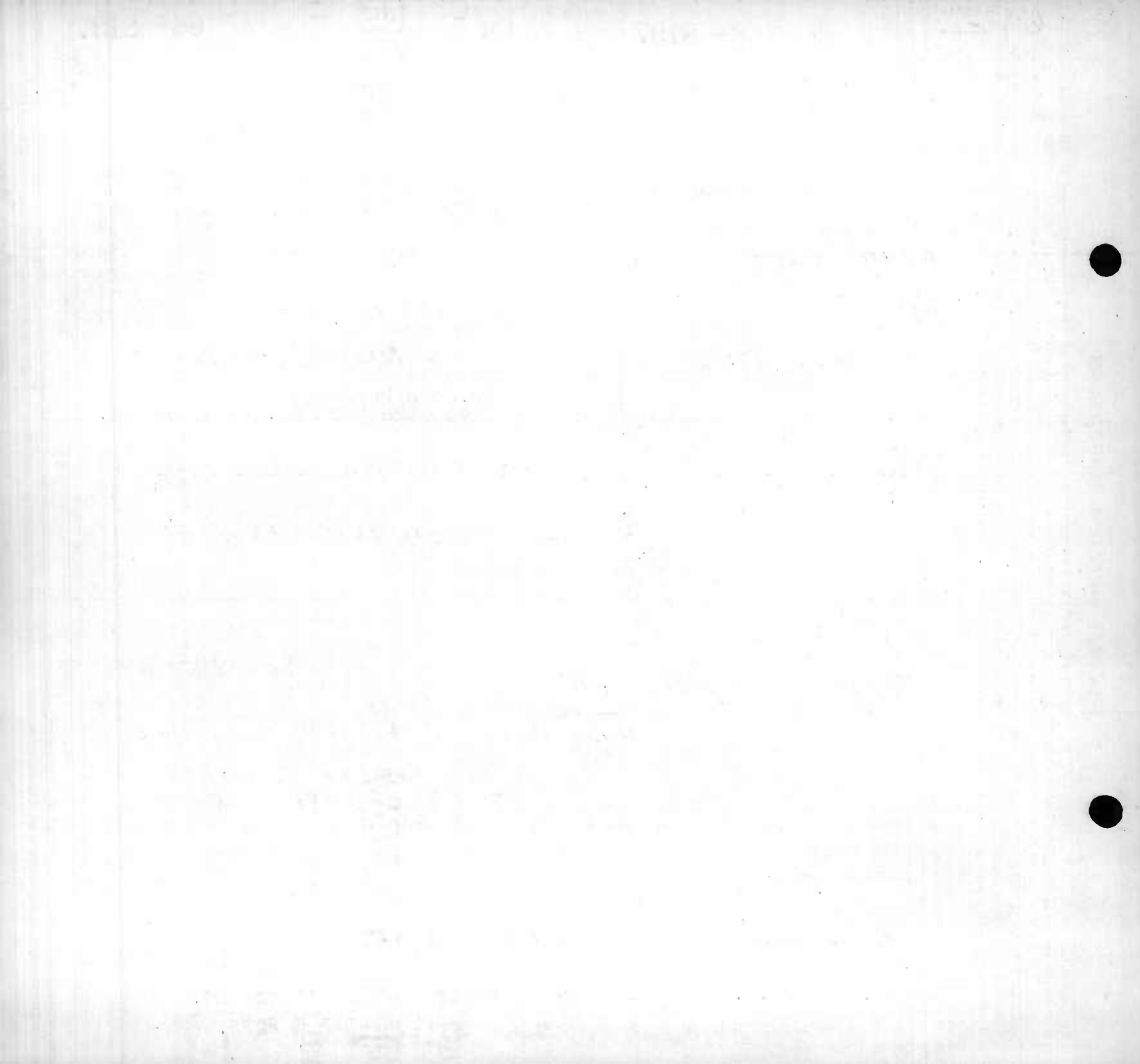
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 8197 CERTIFICATE OF DEATH

REG. NO. 68- 8197

BIRTH NO.		1. NAME OF DECEASED (Type or Print) SARAH BARRANCO		2. DATE AND HOUR OF DEATH AUGUST 5, 1968 1 <sup>16</sup> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 MARYLAND GENERAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND (BOLTON HILL N. HOME) B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1907 SHERWOOD AVENUE	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/7/1885	9. AGE (In years lost birthday) 83	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
13. FATHER'S NAME WILLIAM Stinebaugh			14. MOTHER'S MAIDEN NAME MARY Lowman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. John Barranco 2108 Firethorn Rd. Baltimore Md. 21220	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease or injury or complication which caused death.) E903.7 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A) & (B) FRACTURED HIP				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASPIRATION PNEUMONIA (B) INTERTROCHANTERIC FX @ HIP (C)	
19A. DATE OF OPERATION 17/31/68				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED FRACTURED HIP	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) Nursing Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Bolton Hill Nursing Home 14-01	
21D. TIME OF INJURY (APPROX.) 7-23-68		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? PATIENT SLIPPED & FELL	
22. I certify that (I) (this hospital) attended the deceased from 7-23-68 to 8-5-68, that (I) (we) last saw the deceased alive on 8-5-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>				23B. DATE SIGNED 8-5-68	
23C. PHYSICIAN'S NAME (Type) CONSOLATOR C. PALAD JR. MD				23D. ADDRESS M.G.H.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 8. 1968		24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	
24D. LOCATION Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 12 1968			
25B. NAME OF REGISTRAR Robert E. Fairman		25C. FUNERAL DIRECTOR HENRY SANDER & SONS, INC. Baltimore Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		68- 8198		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68- 8198	
M.E. CASE NO.				1. NAME OF DECEASED			
(Type or Print)				Merrick G. Shawe			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				2. DATE AND HOUR OF DEATH			
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE B. COUNTY			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
44 Union Memorial Hospital				MD. Baltimore			
33rd & Calvert Sts.				D. STREET ADDRESS (If rural, give location)			
Baltimore				2728 St. Paul St.			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Male		White		Married		5/15/90	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Civil Engineer				Cincinnati, Ohio		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Merrick Shawe				Julie Hazlett			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Unknown		426-40-3972		Edna B. Shawe-2728 St. Paul Street			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				3 yrs.			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) Metastatic Carcinoma of Colon			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) CS			
19A. DATE OF OPERATION				20A. AUTOPSY? (Yes or No)			
0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from July 15, 1968 to August 8, 1968, that (we) lost the deceased on August 8, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Chas. R. Gosh				Aug. 8, 1968			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
M.D.				M.D. Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8-10-68		Loudon Park Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 12 1968		J. B. E. Shawe		Ellsworth Armacost		4600 Liberty Hgts. Av.	

*Handwritten signature*

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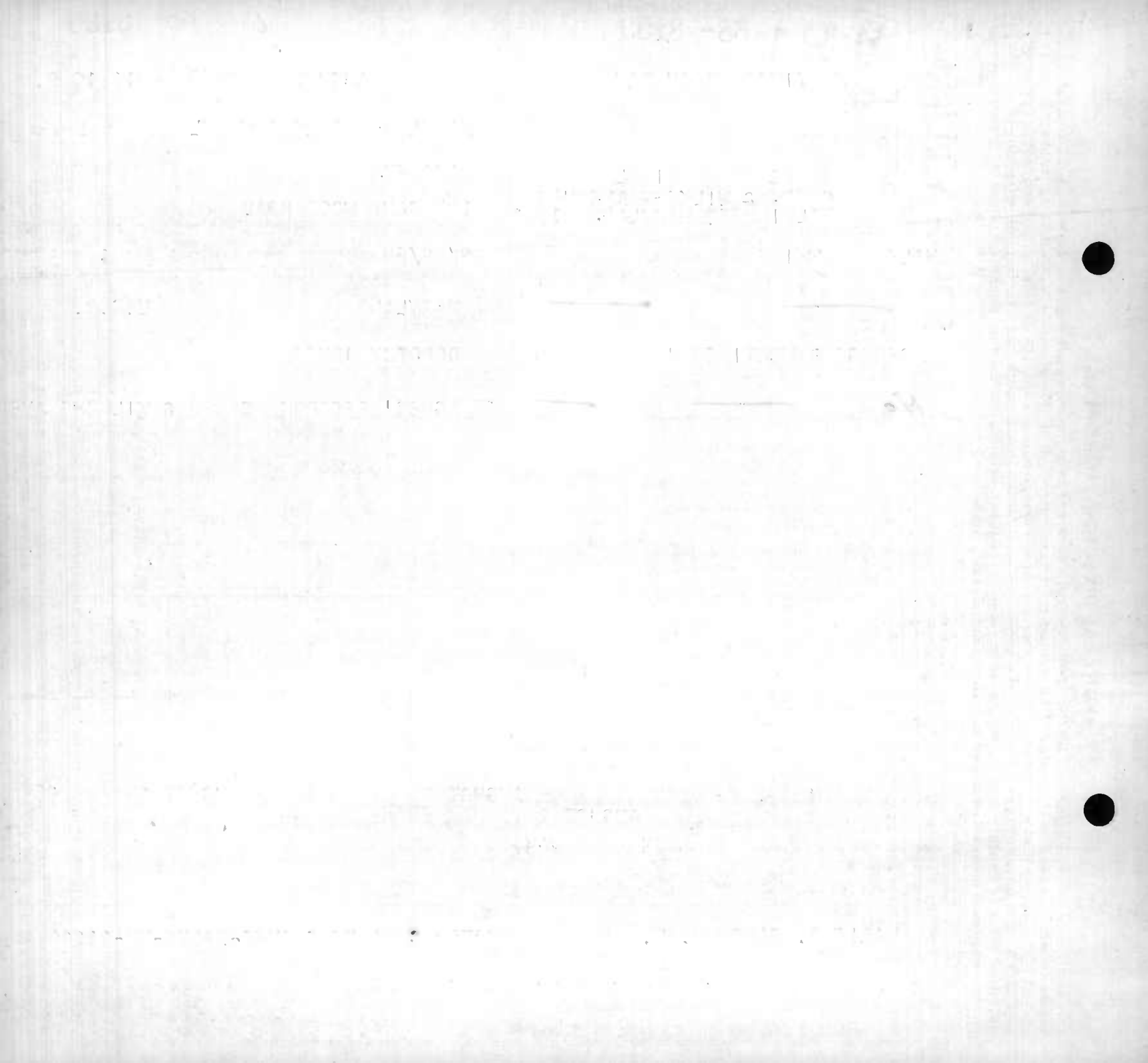
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8199	
BIRTH NO. 68-16317		68- 8199			
1. NAME OF DECEASED (Type or Print) MORTIMER, BABY BOY			2. DATE AND HOUR OF DEATH AUGUST 2, 1968 11:10 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL 52-00		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229			C. CITY OR TOWN PASADENA D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 184 SOUTHWOOD ROAD					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08/02/68	9. AGE (In years last birthday) 1	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 38
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE B MORTIMER, JR		14. MOTHER'S MAIDEN NAME DOROTHY JONES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ST AGNES' RECORDS	
18. 776.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Inmaturity DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. 762.5 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Intrauterine anoxia			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If In Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from AUGUST 2 19 68 to AUGUST 2 19 68, that (I) (we) last saw the deceased alive on AUGUST 2 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Maria D. Giron M.D.		23B. DATE SIGNED Aug. 3, 1968		23C. PHYSICIAN'S NAME (Type) MARIA D. GIRON M. D.	
23D. ADDRESS CATON & WILKENS AVES-BALTO-MD-21229		24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 8/8/68	
24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 12 1968	
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc.		25D. ADDRESS 1501 E. Fort Avenue	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8200

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 8200

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ALICE OWENS</b>		2. DATE AND HOUR OF DEATH <b>8/7/68 11<sup>40</sup> A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>15-13</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL OF BALTIMORE INC</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>F</b> 6. RACE <b>N</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>8/22/11</b>		9. AGE (In years lost birthday) <b>56</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Fred OWENS</b>		
14. MOTHER'S MAIDEN NAME <b>MARY ETTA WARREN</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <b>084-07-7572</b>			17. INFORMANT ADDRESS <b>LILLIAN PATTERSON 3124 WOODLAND AVE.</b>		
18. <b>011.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>GRAM NEGATIVE SHOCK</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>GRAM NEGATIVE PNEUMONIA + SEPSIS</b> <b>POSSIBLE TUBERCULOSIS</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b> <b>9 days</b> <b>9 days</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>CHRONIC LIVER DISEASE</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>? YEARS</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>July 29</b> 19 <b>68</b> to <b>August 7</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>August 7</b> 19 <b>68</b> and that (n) (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Howard Ronald Friedman M.D.</b>				23B. DATE SIGNED <b>August 7, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>HOWARD RONALD FRIEDMAN M.D.</b>				23D. ADDRESS <b>Sinai Hospital of Baltimore, Inc.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/10/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MT. AUBURN</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR ADDRESS <b>CHARLES A. RICE 661 W. BARRE ST.</b>			

Autumn

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8201

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 8201

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ANGELINA SHEPPARD</b>		2. DATE AND HOUR OF DEATH <b>AUG. 6, 1968, 12:15 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>11-02</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>MERCY HOSPITAL</b> <b>301 ST. PAUL PLACE</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>808 ST. PAUL ST.</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/15/1892</b>	9. AGE (In years last birthday) <b>75</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOUSE WORK</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>	
13. FATHER'S NAME <b>JOSEPH KESSLER</b>		14. MOTHER'S MAIDEN NAME <b>ANNA ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>HARRY N. SHEPPARD</b>	
				ADDRESS <b>210 HERRING CT. BALTO., 21231, MD.</b>	
18. <b>412.31-250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>RESPIRATORY ARREST</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Few minutes</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CARDIOVASCULAR ACCIDENT</b>			DUE TO, OR AS A CONSEQUENCE OF: <b>1 DAY</b>		
			(C) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>DIABETES MELLITUS, UNCONTROLLED</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>AUG. 4</b> 19 <b>68</b> to <b>AUG. 6</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>P. SALUD</b>				23B. DATE SIGNED <b>AUG. 6, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>PONCIANO V. SALUD</b>		23D. ADDRESS <b>M.D. MERCY HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-9-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT. CARMEL CEM.</b>	
24D. LOCATION (City, town, or county) (State) <b>5712 O'DONNELL ST. BALTO., MD.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Charles J. Geiler</b>	
				ADDRESS <b>901 S. CONNLYNG ST. BALTO., 21224, MD.</b>	



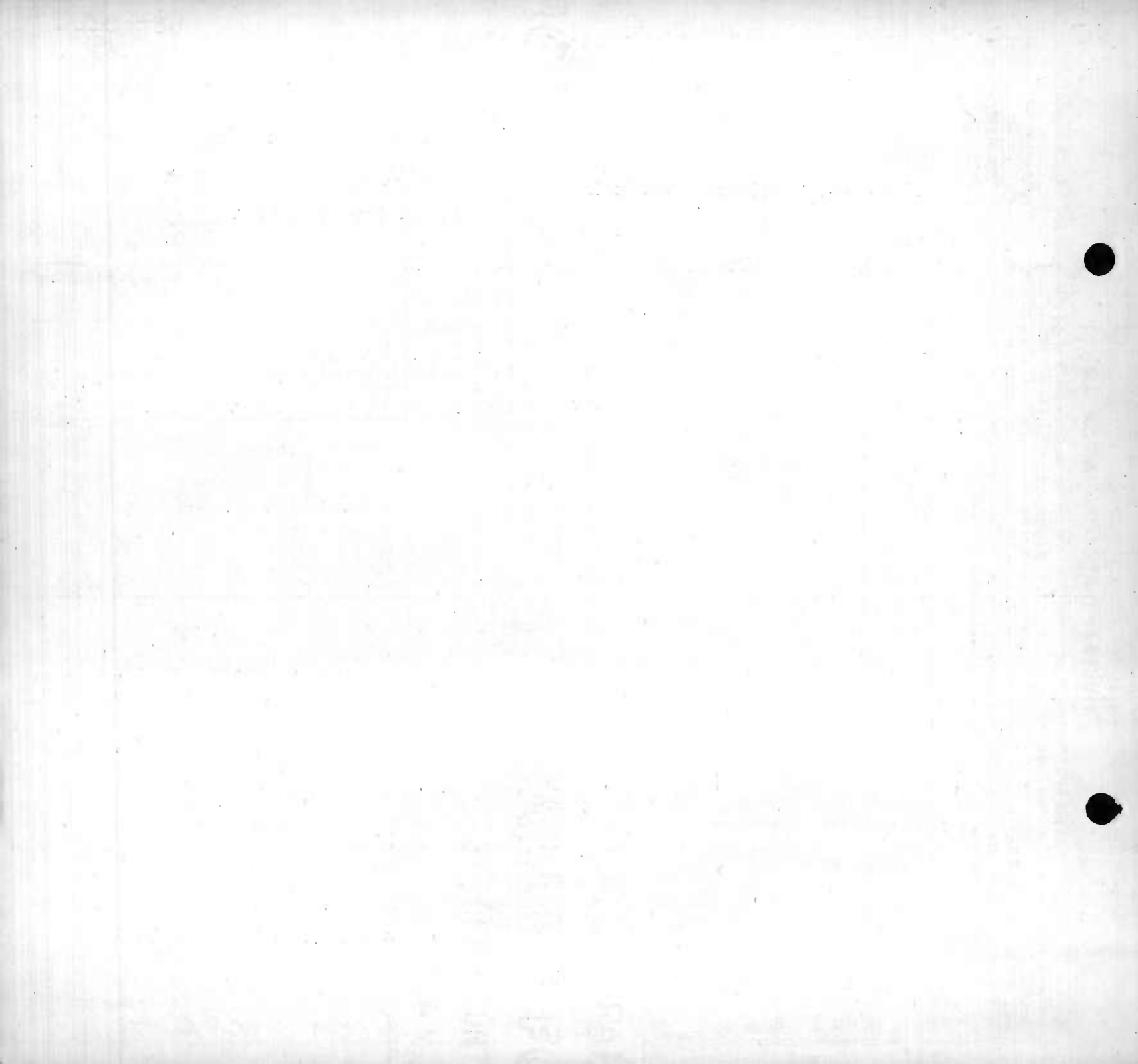
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8202 CERTIFICATE OF DEATH

REG. NO. 68- 8202

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Geo HEGAN, Joseph</u>		2. DATE AND HOUR OF DEATH <u>8 PM 8/5/1968</u>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Johns Hopkins Hospital</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? <u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>839 N. Luzerne Ave.</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-23-13</u>	9. AGE (In years lost birthday) <u>55</u>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>BOTTLING.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>BENJAMIN</u>				14. MOTHER'S MAIDEN NAME <u>VERDI MACNAMARA</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>216-03-1032</u>		17. INFORMANT ADDRESS <u>HELEN BOHCEGAN 839 N. LUZERNE AVE.</u>			
18. <u>57191</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>HEPATIC COMA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>GI Hemorrhage + Cirrhosis</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 days</u> <u>Prob years</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>381.0 II</u>							
19A. DATE OF OPERATION <u>8</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>8/1/68</u> to <u>8/5/68</u> and that (I) (we) lost saw the deceased olive on <u>8/5/68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Marc Lippman</u> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/5/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Marc Lippman MD</u> DEGREE				23D. ADDRESS <u>The Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/8/68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART CEM.</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 12 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>BDABROWSKI 12818 E. BALTO. ST.</u>		ADDRESS	



68- 8203

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8203

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>SARAH PRAYLOW</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 East Falls &amp; President Streets</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>May 17, 1968 11:02 A.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>1-1-20</b>		10. AGE (In years last birthday) <b>48</b>	
11. BIRTHPLACE (State or foreign country) <b>S.O.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>ALLEN CHINA</b>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
15. MOTHER'S MAIDEN NAME <b>ANNIE ?</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Alberta Praylow 851 George St 6J</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>E9541X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Found in water, presumed drowned</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>water</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>E. Falls &amp; President Sts.</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>?</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>Apparently jumped into water</b>		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/10/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>mt. Calvary</b>		24D. LOCATION (City, town, or county) (State) <b>Q. A. County Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>	
25C. FUNERAL DIRECTOR <b>Joseph B. Locke</b>		ADDRESS <b>1304 N. Central</b>	

2058

2058-50

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WALLLEY (1944)

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8204 CERTIFICATE OF DEATH

REG. NO. 68- 8204

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JOSEPH R. PISCOR</b>		2. DATE AND HOUR OF DEATH <b>8/10/68</b> <b>1045 P</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Baltimore city</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 JOHNS HOPKINS HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE 21234</b>		D. INSIDE CITY LIMITS? <b>YES</b> <b>NO</b>	
		E. STREET AND NUMBER <b>620 S. MONTFORD AVE.</b>			
5. SEX <b>Male</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/21/95</b>	9. AGE (In years lost birthday) <b>73</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHIP RICGER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Piscor</b>		14. MOTHER'S MAIDEN NAME <b>Eva Sobus</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b> <b>WW I</b>		16. SOCIAL SECURITY NO. <b>214-03-2344</b>		17. INFORMANT <b>MRS. MARY JANKA-620 S. MONTFORD AVE.</b>	
18. <b>410.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL INFARCTION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ASCVD</b> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>420.1 II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8/7</b> <b>1968</b> to <b>8/10</b> <b>1968</b> , that (I) <del>last</del> last saw the deceased alive on <b>8/10</b> <b>1968</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> (did) <del>not</del> view the body after death.					
23A. SIGNATURE <b>Michael D. Lutz, M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>8/10/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>MICHAEL D. LUTZ, M.D.</b>		23D. ADDRESS <b>DEPT OF MED. JHH</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/14/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>GARDENS OF FAITH</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE COUNTY, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fathman</b>		25C. FUNERAL DIRECTOR <b>GEORGE A. WEBER-705 S. ANN ST. 21231</b>	

2000-11-19-2000

2000-11-19-2000

WFO

JOHN HOPKINS HOSPITAL

BALTIMORE, MD  
630 S. MONTFORD AVE.

M. (CANCER)

2/21/92

THE KIDNEY

USA

Yes

APPROPRIATE EXAMINATION

ASAP

NO

MICHAEL D. TUTT, M.D.  
MICHAEL D. TUTT, M.D.

DEPT OF MED - 100

2/21/92

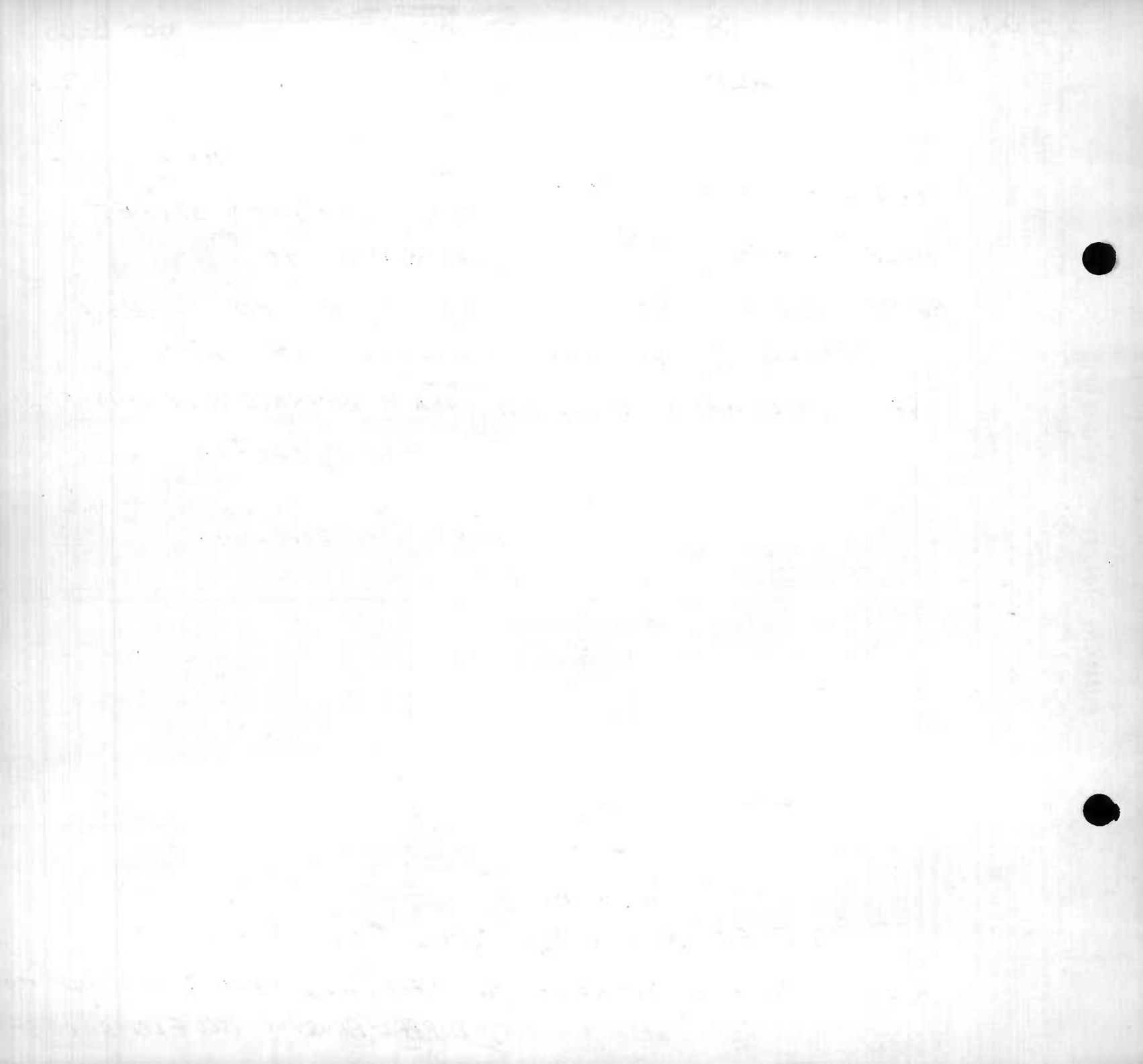
2/10/92

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8205 CERTIFICATE OF DEATH

REG. NO. 68- 8205

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ALPHONSE C BANKARD SR		AUG 10 1968 2:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				MARYLAND	
1915 E LOMBARD STREET				C. CITY OR TOWN BALTIMORE	
				D. HOME CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1915 E LOMBARD STREET	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)
MALE	WHITE			APR 30 1898	70
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED FIREMAN		BALTO CITY		BALTIMORE MD	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
JACOB J BANKARD				WILHELMINA LINK.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES		WORLD WAR I		ANNA M. BANKARD 1915 E LOMBARD ST	
		217-32-9021			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
410.9 I		Acute Myocardial Infarction		24 Hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Chronic Myocarditis		9 yrs	
		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 1959 to Aug. 10 1968, that (I) (we) last saw the deceased alive on Aug. 9 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE I. J. Feinglos MD				23B. DATE SIGNED 8/12/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
I. J. FEINGLOS MD				2002 E. Pratt St	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		AUG 14 1968		HOLY REDEEMER CEM	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 13 1968		R. E. Feinglos		DIPPEL BROS INC 1800 E LOMBARD ST	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-8206</u>
68-8206		<b>CERTIFICATE OF DEATH</b>		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>FIGIEL, Stephen Peter</u>		
2. DATE AND HOUR OF DEATH <u>8-9-68 4:55 pm</u>		M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Balto Gen. Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>ANNE ARUNDEL</u> C. CITY OR TOWN <u>Balto. Md.</u> D. INSIDE CITY LIMITS? <u>YES</u> NO <u>NO</u> E. STREET AND NUMBER <u>640 S STREEPER ST</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-12-84</u>	9. AGE (In years lost birthday) <u>83</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Balto. City Bureau of Highways</u>		11. BIRTHPLACE (State or foreign country) <u>POLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Figiel</u>		
14. MOTHER'S MAIDEN NAME <u>Frances Pierog</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>212-03-5964</u>		17. INFORMANT <u>Mrs. Bernard Backof</u>		
18. <u>440.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Arteriosclerotic Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>450.0 II</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>II</u>		20A. AUTOPSY? (Yes or No) <u>No</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>At Work</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>At Work</u>		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>Aug 3 1968</u>		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR? <u>Aug 3 1968 to Aug 9 1968</u>				
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 3 1968</u> to <u>Aug 9 1968</u> , that (I) (we) last saw the deceased alive on <u>Aug 9 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Sang Yoon Rhim</u>		23B. DATE SIGNED <u>Aug 9 '68</u>		23C. PHYSICIAN'S NAME (Type) <u>Sang Yoon RHIM</u>
23D. ADDRESS <u>South Balto. Gen. Hosp.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>Aug 12, 1968</u>		24C. NAME OF CEMETERY or CREMATORY <u>St Stanislaus Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 12 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Faldy</u>		25C. FUNERAL DIRECTOR <u>Dippel Bros Inc.</u>
25D. ADDRESS <u>7110 Belair Rd.</u>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 68- 8207 CERTIFICATE OF DEATH

REG. NO.

68- 8207

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

LEMUEL K. MENTZELL

2. DATE AND HOUR OF DEATH

8-5-68 ~~8-5-68~~ 7:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNIVERSITY OF MARYLAND

38 HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

MARRIOTTSVILLE

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

RFD #1 MARRIOTTSVILLE MD.

5. SEX

MALE

6. RACE

CAUCASIAN

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

5-27-87

9. AGE (In years last birthday)

81

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Conductor

10B. KIND OF BUSINESS OR INDUSTRY

B & O RR

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Edward Mentzell

14. MOTHER'S MAIDEN NAME

MARY JANE WHITLEY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

705 12 3581

17. INFORMANT

ADDRESS

Mrs. Alta B. Mentzell RFD #1, Marriottsville, Md.

18. ~~188X~~ I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4 yrs.

181.0 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Mohammed N. JAMMAD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

AUG 12 1968

Robert E. Jenkins

Wm J. Tickner & Sons, Balt. Md.

1

Caution and Control  
Theorem of statistics

Michael J. Fox

Received 1/1/81

68- 8208 CERTIFICATE OF DEATH

REG. NO. 68- 8208

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>KATHERINE D. SMITH</b>		2. DATE AND HOUR OF DEATH <b>8/9/68 12 30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL 42</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO.</b> C. CITY OR TOWN <b>LUTHERVILLE (2093)</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>202 CRICKETT COURT</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/8/98</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED-SECRETARY</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O RR</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, Md.</b>	
13. FATHER'S NAME <b>GEORGE W.F. SCHWINGER</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>121-46-9289</b>		17. INFORMANT <b>MISS MAY SCHWINGER (SAME)</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>E904.0 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1A: <b>PERICARDIAL EFFUSION</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>PULMONARY EMBOLISM</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Right Lower Extremity Embolism</b> (B) <b>Fr Right Leg</b> DUE TO, OR AS A CONSEQUENCE OF: <b>CASE FOR FRACTURED RT 4th + 5th METAPHALANX</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>		
19A. DATE OF OPERATION <b>8/8/68</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fract Pulmonary Embolism</b>		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>202 Cricket Ct. Lutherville, Md.</b>
21D. TIME OF INJURY (APPROX.) <b>7-16-68</b>			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fell at Home</b>
22. I certify that (I) (this hospital) attended the deceased from <b>8/6</b> 19 <b>68</b> to <b>8/9</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/9</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>I. R. Chloca MD</b>			23B. DATE SIGNED <b>8/9/68</b>		23C. PHYSICIAN'S NAME (Type) <b>I. R. CHLOCA, MD</b>
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>8/12/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Park</b>
24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Balto. Co., Md.</b>			25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		
25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>			25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 1905 York Rd. Balto. 12, Md.</b>		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RECEIVED SECRETARY 1942

SECRETARY OF THE ARMY

WASHINGTON, D.C.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 8209 CERTIFICATE OF DEATH

REG. NO. 68- 8209

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Griffin, Osceola</b>		2. DATE AND HOUR OF DEATH <b>August 7, 1968 8 pm</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore city</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSPITAL</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		8. DATE OF BIRTH <b>1891</b> <b>11-13-12</b>	
13. FATHER'S NAME <b>Archibald Castele</b> <del>Archibald Castelle</del>			14. MOTHER'S MAIDEN NAME <b>Margaret Sterling</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-34-6532</b>		17. INFORMANT <b>patient's husband</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>736.9 1250.9</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>DIABETES</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr 45 min</b>		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>331X II</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>CVA</b> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19A. DATE OF OPERATION <b>No</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>Aug 3 1968</b> to <b>Aug 7 1968</b> , that (2) (we) lost saw the deceased alive on <b>Aug 7 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Brian Block</b>				23B. DATE SIGNED <b>Aug 7, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. BRIAN BLOCK</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/10/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Prind Ridge Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>Wm. J. Tichner &amp; Sons Baltimore</b>			

director.

BC. of child born 1/2/19--B 67207--age of  
mother 27 at last birthday.

*[Handwritten signature]*

11. BEAV - Block

1-72-26-1

24

# FUNERAL DIRECTOR: IMPORTANT

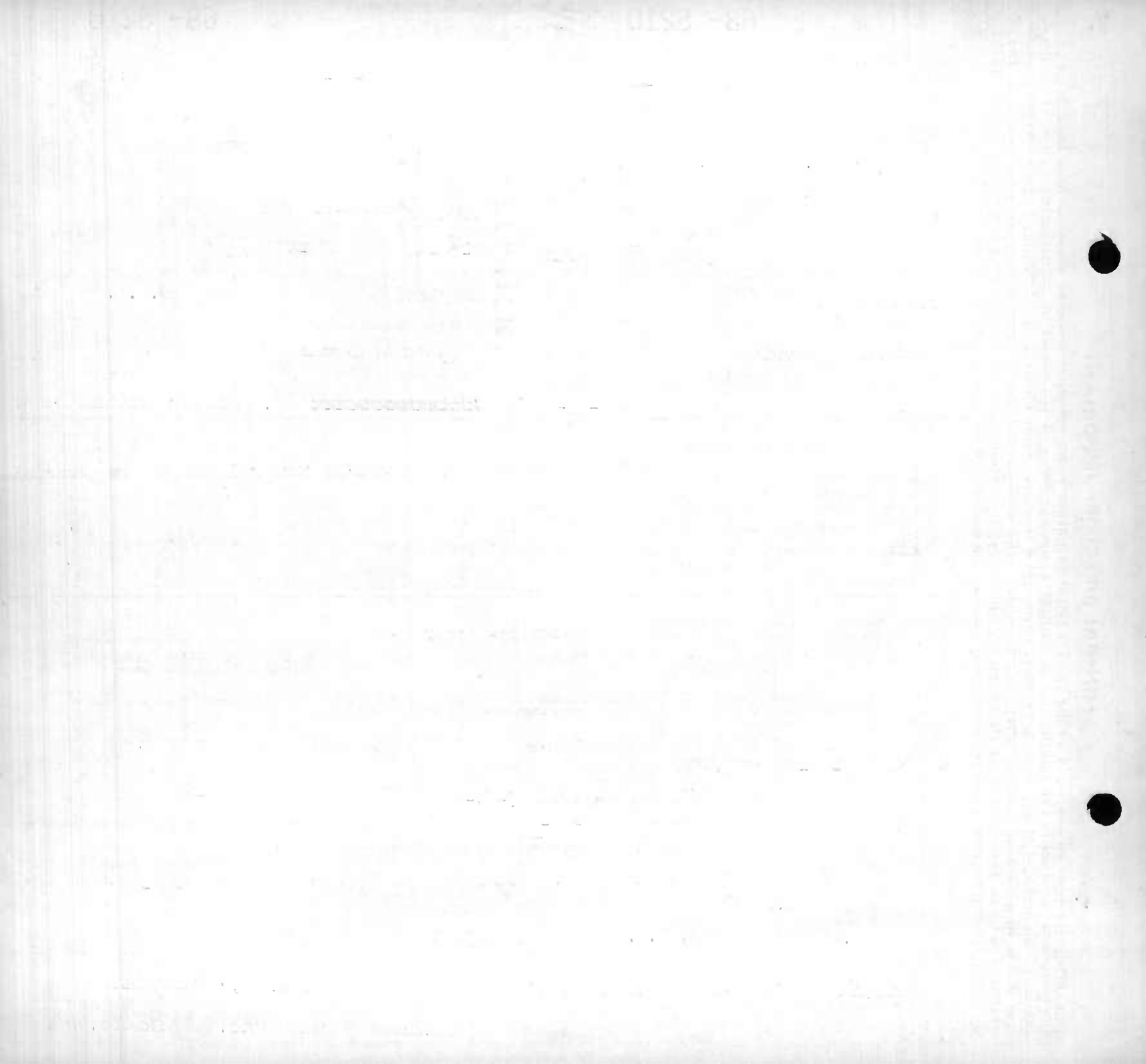
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8210

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 8210

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARKLAND, CATHERINE</b>		2. DATE AND HOUR OF DEATH <b>8-10-68</b> <b>3:35</b> <b>P</b> <b>M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>B olton Hill Nursing Center</b> <b>90</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3505 Glenmore Ave</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-28-94</b>	9. AGE (In years, lost birthday) <b>74</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Richard Council</b>			14. MOTHER'S MAIDEN NAME <b>Emma M Lewis</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-30-1703A</b>		17. INFORMANT ADDRESS <b>Admission Record M. Audrey Drimal Same</b>	
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>ASCVD</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Right middle cerebral thrombosis sever al</b> DUE TO, OR AS A CONSEQUENCE OF: <b>days</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. <b>422.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			<b>Decubitus ulcer back</b> <b>?</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>8-10-68 6:30 PM</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>7-28-68</b> 19__ to <b>8-10-68</b> 19__, that <b>(X)</b> (we) last saw the deceased alive on <b>8-10-68</b> 19__ and that in <b>(X)</b> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <b>(X)</b> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>E. Ellsworth Cook</b> DEGREE				23B. DATE SIGNED <b>8-10-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>E. ELLSWORTH COOK, M.D.</b> DEGREE				23D. ADDRESS <b>2431 Maryland Av enue</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8/13/68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Baltimore</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J Ruck Inc. Balto. Md</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8211
BIRTH NO. 68- 8211		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>William Everett Burton</u>		2. DATE AND HOUR OF DEATH <u>August 10, 1968 9:15 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>THE UNION MEMORIAL HOSPITAL</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>9-3-68</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>27-44</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5506 HILLTOP AVE. - 21206</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/29/1909</u>	9. AGE (In years lost birthday) <u>70</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Railroad ENGINEER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>B &amp; O R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>FREDERICK BURTON</u>		
14. MOTHER'S MAIDEN NAME <u>BERTHA HILL</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>705-12-3762</u>		17. INFORMANT <u>DAUGHTER</u> <u>8023 Highpoint Rd.</u> <u>MRS. VIRGINIA G. DEN, BALTO. 34, MD.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>410.9 I</u> <u>Acute Myocardial Infarction</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Thrombosis of right coronary artery</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary edema</u> (C) <u>V.S.</u>		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>420.1 II</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>August 10</u> 19 <u>68</u> to <u>August</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>August 10</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>did</u> (did not) view the body after death.				
23A. SIGNATURE <u>Chun Kee Ryu</u> M.D. DEGREE		23B. DATE SIGNED <u>August 10, 1968</u>		23C. PHYSICIAN'S NAME (Type) <u>CHUN KEE RYU MD.</u> M.D. DEGREE
23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>8/13/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 12 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Tarkenton</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Balto. Md.</u>

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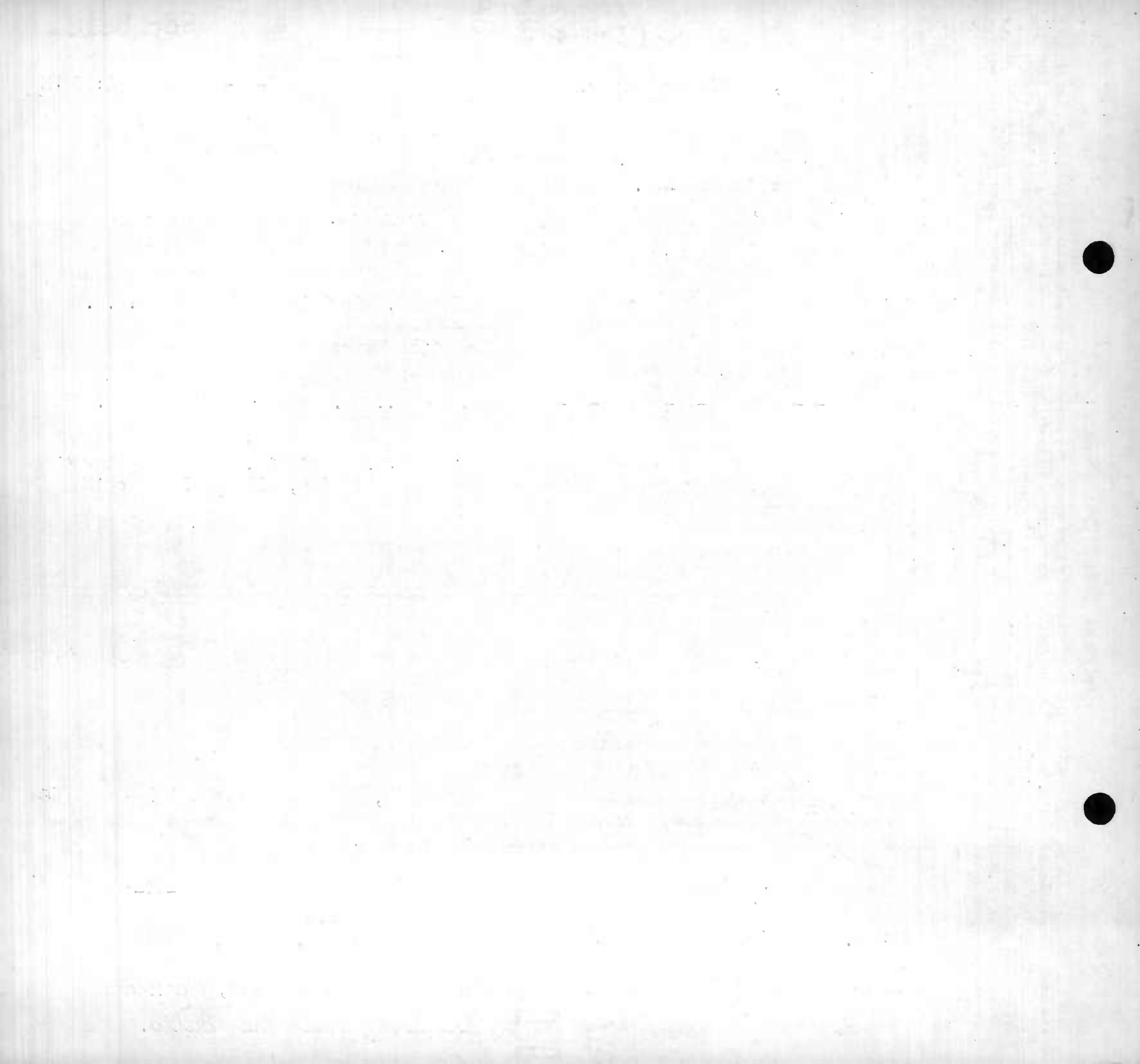
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

## 68- 8212 CERTIFICATE OF DEATH

REG. NO. 68- 8212

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>DIXON, Austin Brokenberry</b>		2. DATE AND HOUR OF DEATH <b>8-10-68 4:35 PM M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 Veterans Administration Hospital</b> <b>3900 Loch Raven Blvd.</b> <b>Baltimore, Maryland 21218</b>		E. STREET AND NUMBER <b>3018 Mary Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/27/97</b>	9. AGE (In years lost birthday) <b>71</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Tidwell, Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George W. Dixon</b>		14. MOTHER'S MAIDEN NAME <b>Redelia Evans</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 10-5-18 to 12-17-18</b>		16. SOCIAL SECURITY NO. <b>217-12-6590</b>		17. INFORMANT <b>Records</b> ADDRESS <b>VAH, Balto., Md. 3900 Loch Raven Blvd. 21218</b>	
18. <b>011.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Tuberculous Pneumonia,</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Greater than 1 Month</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Massive, Bilateral</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from <b>August 10, 19 68</b> to <b>August 10, 19 68</b> , that (2) (we) lost saw the deceased alive on <b>August 10, 19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Elmo M. Gayoso</i>		23B. DATE SIGNED <b>8-11-68</b>			
23C. PHYSICIAN'S NAME (Type) <b>ELMO M. GAYOSO MD</b>		23D. ADDRESS <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/14/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Pk</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Leonard J Ruck Inc</b>		25D. ADDRESS <b>Balto. Md</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

68- 8213

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 8213

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ROBBINS HERMAN</b>		2. DATE AND HOUR OF DEATH <b>8-11-1968 2-15 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>CHURCH HOME AND HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>26-01</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME AND HOSPITAL</b>			C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <b>5415 MAYVIEW AVENUE (6)</b>					
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-14-1923</b>	9. AGE (In years last birthday) <b>45 yrs</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>REFRIGERATION CO</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
13. FATHER'S NAME <b>CHARLES ROBBINS</b>			14. MOTHER'S MAIDEN NAME <b>MARY ARNOLD</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 11</b>		16. SOCIAL SECURITY NO. <b>216-14-8701</b>		17. INFORMANT <b>Evelyn J Robbins</b>	
				ADDRESS <b>Same</b>	
18. <b>1580 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Retroperitoneal Sarcoma with Secondaries in the lung, kidneys, prostate bladder &amp; pericardium - years</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>158X II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>8-6-1968</b> to <b>8-11-1968</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>8-11-1968</b> and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(X)</b> (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>J. Nidiry</b>			23B. DATE SIGNED <b>8-11-1968</b>		
23C. PHYSICIAN'S NAME (Type) <b>Dr. JOSEPH NIDIRY</b>			23D. ADDRESS <b>CHURCH HOME AND HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/14/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Pk</b>	
24D. LOCATION <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Leonard J Ruck Inc Balto. Md</b>	

Revised 1964  
with comments  
by J. H. ...  
...

## CERTIFICATE OF DEATH

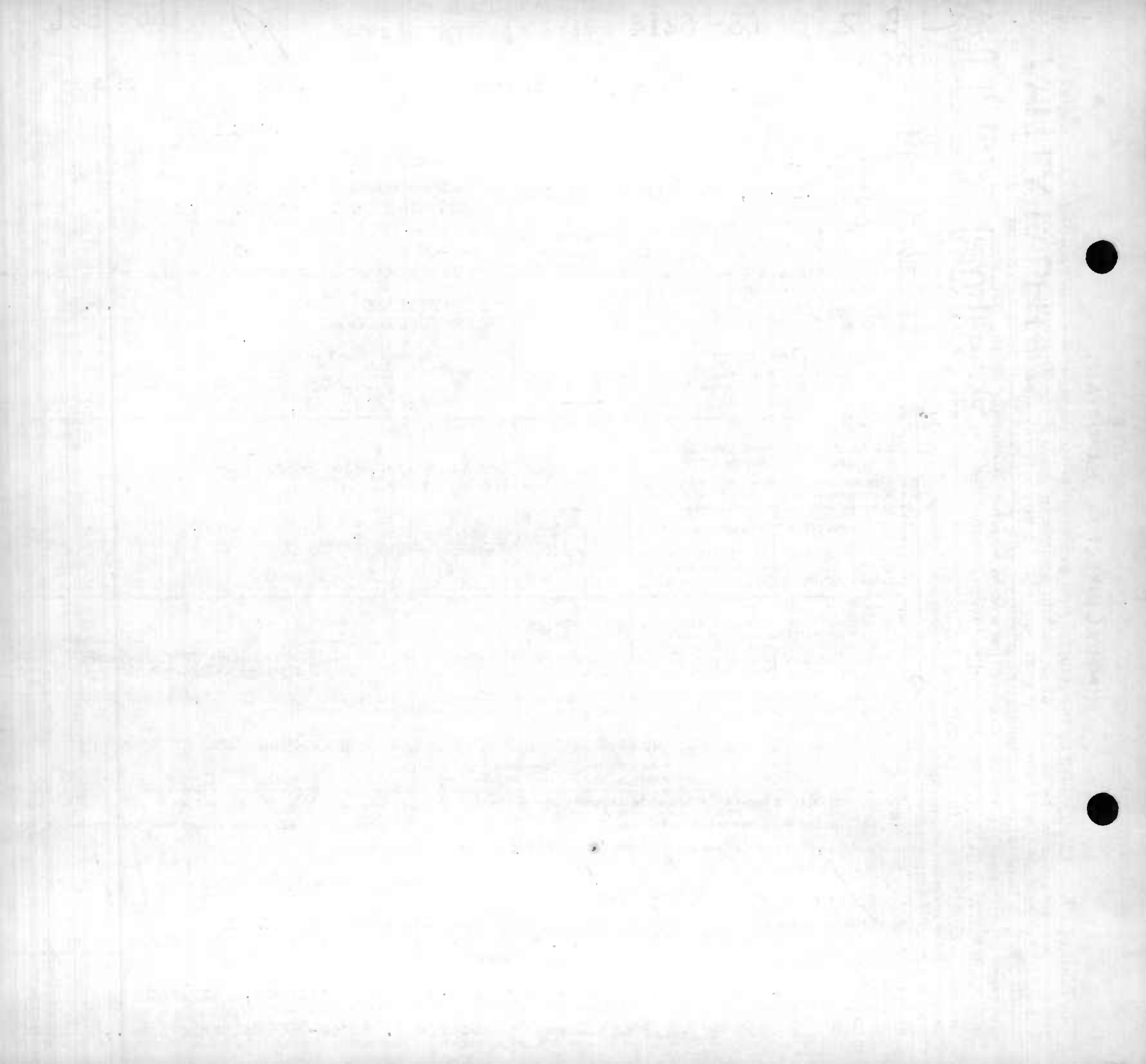
REG. NO.

68- 8214

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

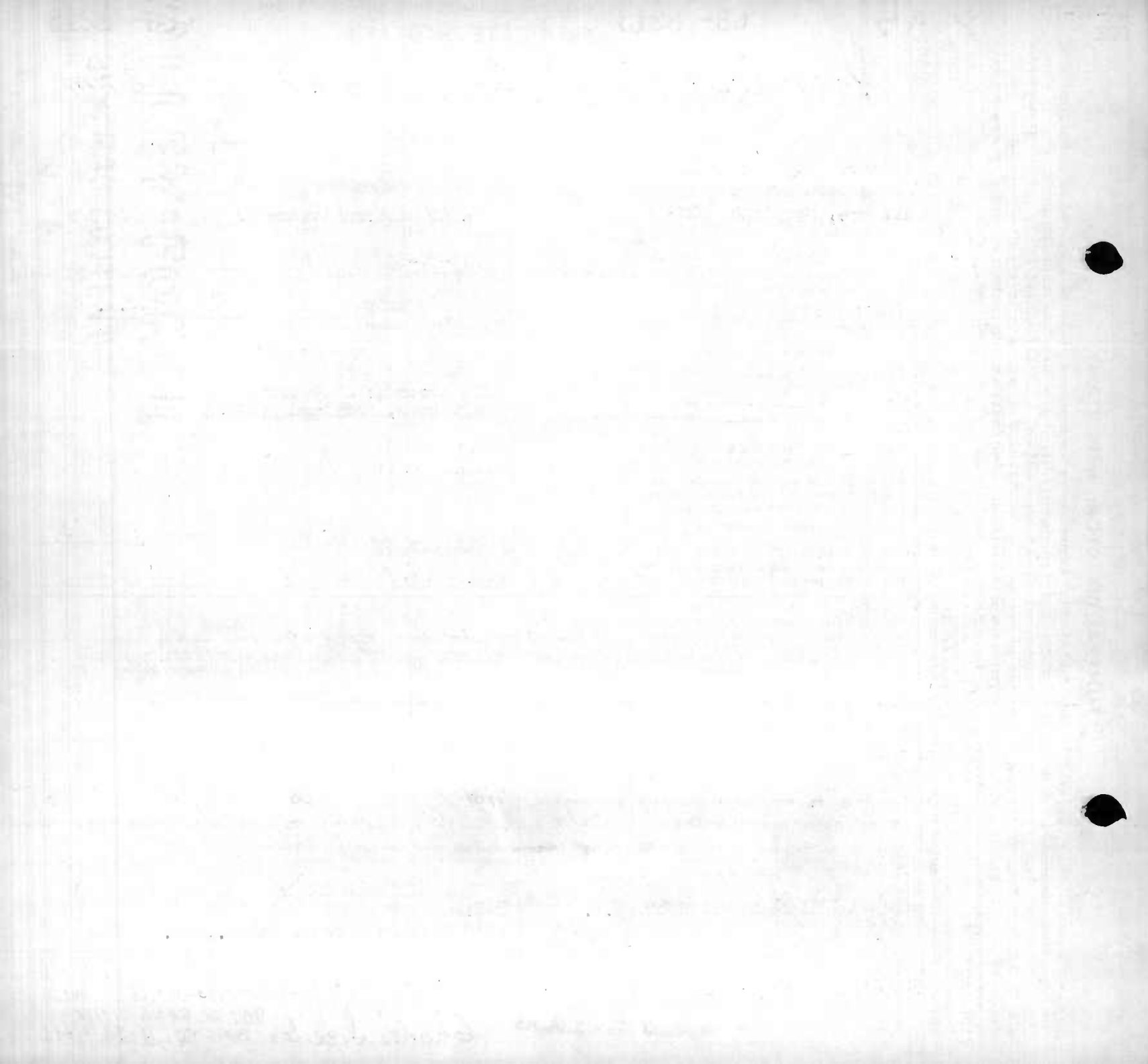
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ANNIE W LOTZ (Anna Elizabeth Lotz)		AUGUST 8, 1968 2:25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE 31 BALTIMORE, CI MARYLAND #21224		MARYLAND ANNE ARUNDEL Co 52-00			
C. CITY OR TOWN PASADENA		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 207 TH STREET GREEN, HAVEN					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-9-08	9. AGE (In years last birthday) 59	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Joseph Wilchinsky		14. MOTHER'S MAIDEN NAME Agnes Paulauchkas	
15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ----		17. INFORMANT ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE RECORDS: BALTIMORE, MARYLAND #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Arrest (B) DUE TO, OR AS A CONSEQUENCE OF: Hydrocephalus 2° to C & S surgery (C) DUE TO, OR AS A CONSEQUENCE OF: Supra cellular Meningioma Septicemia			
19A. DATE OF OPERATION 223X II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6/19 1968 to 8/8 1968, that (2) (we) lost saw the deceased alive on 8/8 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Leonard Feingold		23B. DATE SIGNED 8/8/68		23C. PHYSICIAN'S NAME (Type) LEONARD FEINGOLD M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-10-1968		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 12 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hwy., Baltimore		ADDRESS			



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

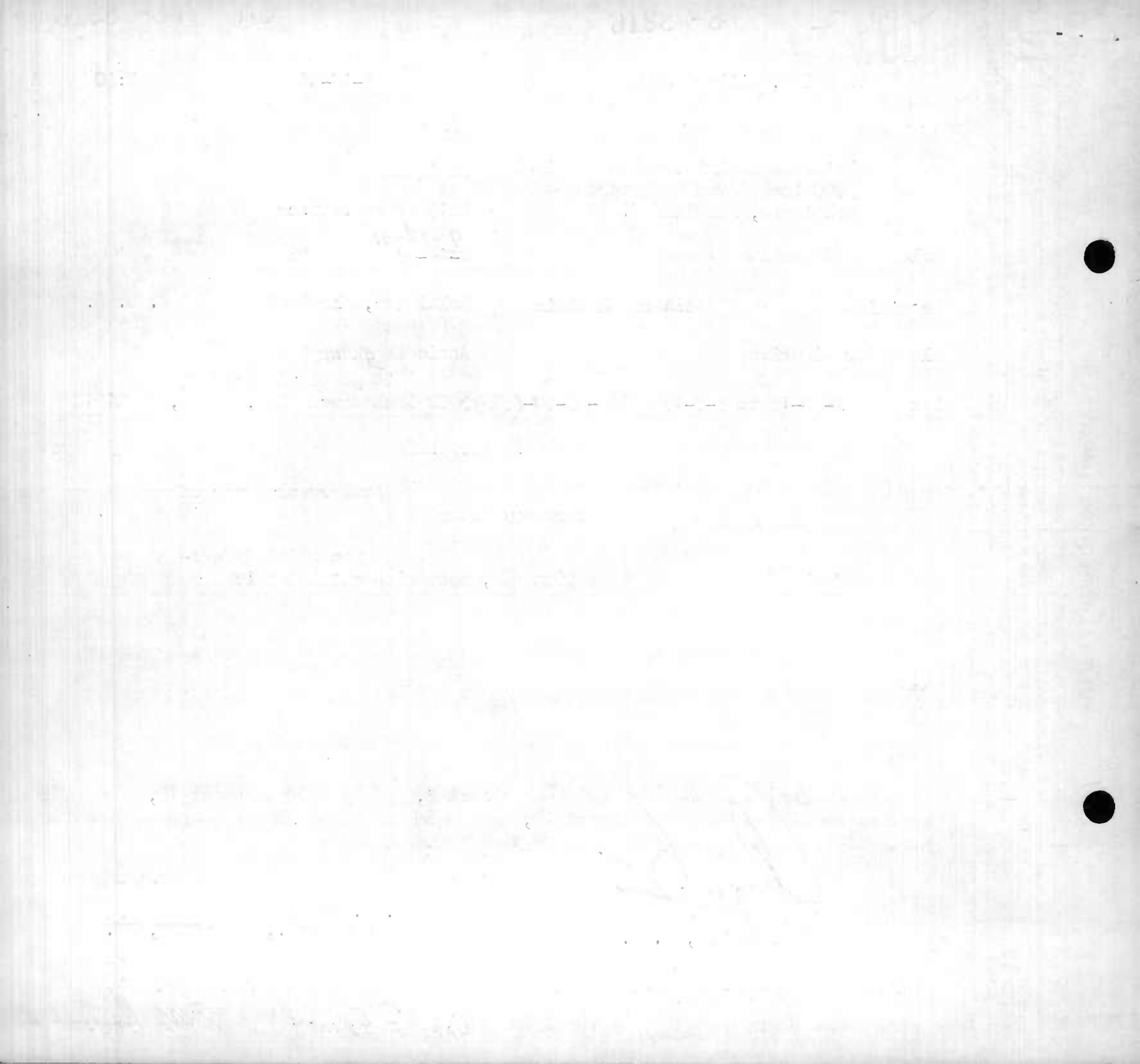
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <b>Youngbar, Frank, Jr.</b>		2. DATE AND HOUR OF DEATH <b>8-4-68</b> <b>8:30 AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland #21224</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4940 Eastern Avenue Street #21224</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-20-84</b>
9. AGE (In years last birthday) <b>83</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Pierre Youngbar</b>		14. MOTHER'S MAIDEN NAME <b>Joanna Kunish</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>BCH Records: 4940 Eastern Avenue</b> <b>Baltimore, Maryland #21224</b>		ADDRESS	
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic Cardiovascular Disease</b> <b>Congestive Heart Failure</b> <b>Chronic Brain Syndrome</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <b>7/8/68</b> to <b>8/4/68</b> , that (we) last saw the deceased alive on <b>8/4/68</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>LEONARD FEINGOLD, M.D.</b>		23B. DATE SIGNED <b>8/4/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>LEONARD FEINGOLD MD</b>		23D. ADDRESS <b>4940 Eastern Avenue, Balto., Md. #21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>8-7-68</b>	24C. NAME OF CEMETERY or CREMATORY <b>SACRED HEART CEM.</b>	24D. LOCATION (City, town, or county) (State) <b>BALTO., CO., MD.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>	25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>	25C. FUNERAL DIRECTOR <b>Charles S. Seiler</b> <b>901 S. CONKLING ST. BALTO., MD.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-362		68- 8216		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 8216	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>DIEDRICH, Millard John</b>			
2. DATE AND HOUR OF DEATH <b>8-10-68</b>   <b>7:40</b> A.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balt Co</b> <b>53-00</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>				C. CITY OR TOWN <b>Hamilton</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b> 6. RACE <b>Caucasian</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>9-18-91</b> <b>8-10-68</b>		9. AGE (In years last birthday) <b>76</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Western Electric</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>Alexander Diedrich</b>			
14. MOTHER'S MAIDEN NAME <b>Annie Langhenry</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>4-30-18 to 5-9-19</b>			
16. SOCIAL SECURITY NO. <b>216-03-70-35A</b>				17. INFORMANT <b>VA Hospital Records</b> ADDRESS <b>3900 Loch Raven Blvd, Balto, Md 21218</b>			
18. <b>412.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Probable arrhythmia</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <b>Artherosclerosis of coronary arteries</b> (B) DUE TO, OR AS A CONSEQUENCE OF <b>Myocardial infarction old, posterior-septal &amp; apical</b> (C) <b>tion old, posterior-septal &amp; apical</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b>	
19. DATE OF OPERATION <b>420.1 II</b>				20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>August 8,</b> 19 <b>68</b> to <b>August 10,</b> 19 <b>68</b> , that (X) (we) lost saw the deceased alive on <b>August 10,</b> 19 <b>68</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Ismael Angulo, M. D.</b>				23B. DATE SIGNED <b>8-10-68</b>		23C. PHYSICIAN'S NAME (Type) <b>Ismael Angulo, M. D.</b>	
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>8-13-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oaklawn Cem.</b>	
24D. LOCATION <b>Baltimore, Md.</b>				25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>	
25C. FUNERAL DIRECTOR <b>Chas. F. Evans &amp; Son</b>				25D. ADDRESS <b>8802 Harford Rd</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8217 CERTIFICATE OF DEATH

REG. NO. 68 8217

1. NAME OF DECEASED (Type or Print) <b>Bernard J. Baumiller Jr.</b>		2. DATE AND HOUR OF DEATH <b>August 9, 1968</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>5211 Springlake Way</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> 8. COUNTY <b>27-12</b>	
5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>5211 Springlake Way</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH <b>3/19/1925</b>	
10. AGE (In years last birthday) <b>43</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Bernard J. Baumiller Sr.</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret Sullivan</b>		15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) <b>Yes WW1</b>	
16. SOCIAL SECURITY NO. <b>212 20 4432</b>		17. INFORMANT <b>Mary E. Baumiller</b>	
18. ADDRESS <b>5211 Springlake Way</b>		19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>410.9 I</b> <b>Secondary Occlusion Sudden</b>	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>420.1 II</b>		21. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A) <b>420.1 II</b>		23. DATE OF OPERATION <b>8/12/68</b>	
24. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Druid Ridge Cemt.</b>		25. AUTOPSY? (Yes or No) <b>NO</b>	
26. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		29. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
30. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		31. HOW DID INJURY OCCUR?	
32. I certify that (I) (this hospital) attended the deceased from <b>Feb 1966</b> to <b>February 1968</b> , that (I) <del>was</del> last saw the deceased alive on <b>Feb 1966</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> (did not) view the body after death.		33. SIGNATURE <b>Charles F. O'Donnell</b> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
34. PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell</b>		35. DATE SIGNED <b>8/10/68</b>	
36. ADDRESS <b>7501 York Rd.</b>		37. NAME OF CEMETERY or CREMATORY <b>Druid Ridge Cemt.</b>	
38. LOCATION (City, town, or county) (State) <b>Pikesville Md.</b>		39. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>	
40. NAME OF REGISTRAR <b>Robert E. Taylor</b>		41. FUNERAL DIRECTOR <b>Mitchell Wiedefeld Home</b>	
42. ADDRESS <b>6300 York Rd.</b>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>MOCARSKY</b> <b>FLORENCE MOKARSKY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>8</b> Day <b>6</b> Year <b>68</b> Hour <b>12:00 a.m.</b> Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>31 City Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>August</b> Day <b>6</b> Year <b>1968</b> Hour <b>12:00 a.m.</b>	
6. SEX <b>Female</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>White</b>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>MAY 14, 1894</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10. AGE (In years last birthday) <b>74</b>		E. STREET AND NUMBER <b>633 Rockaway Beach Ave.</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES LUCAS</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>KATHERINE BONNER</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
17. SOCIAL SECURITY NO. <b>212-26-7608</b>		18. INFORMANT <b>HARRY HAINES</b>	
19. CAUSE OF DEATH <b>E 885 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>E 903.5 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No)		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? <b>Old Eastern Ave. &amp; Stemmers Run Rd.</b>	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>7 21 68 2:00p</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>Lost footing while stepping up onto curb</b>		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/9/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>BALTO. NATL. CEM</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkany</b>	
25C. FUNERAL DIRECTOR <b>J.G. CONNELLY SONS</b>		ADDRESS <b>300 MAC</b>	

WALL

WALL

Released By HEO.  
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

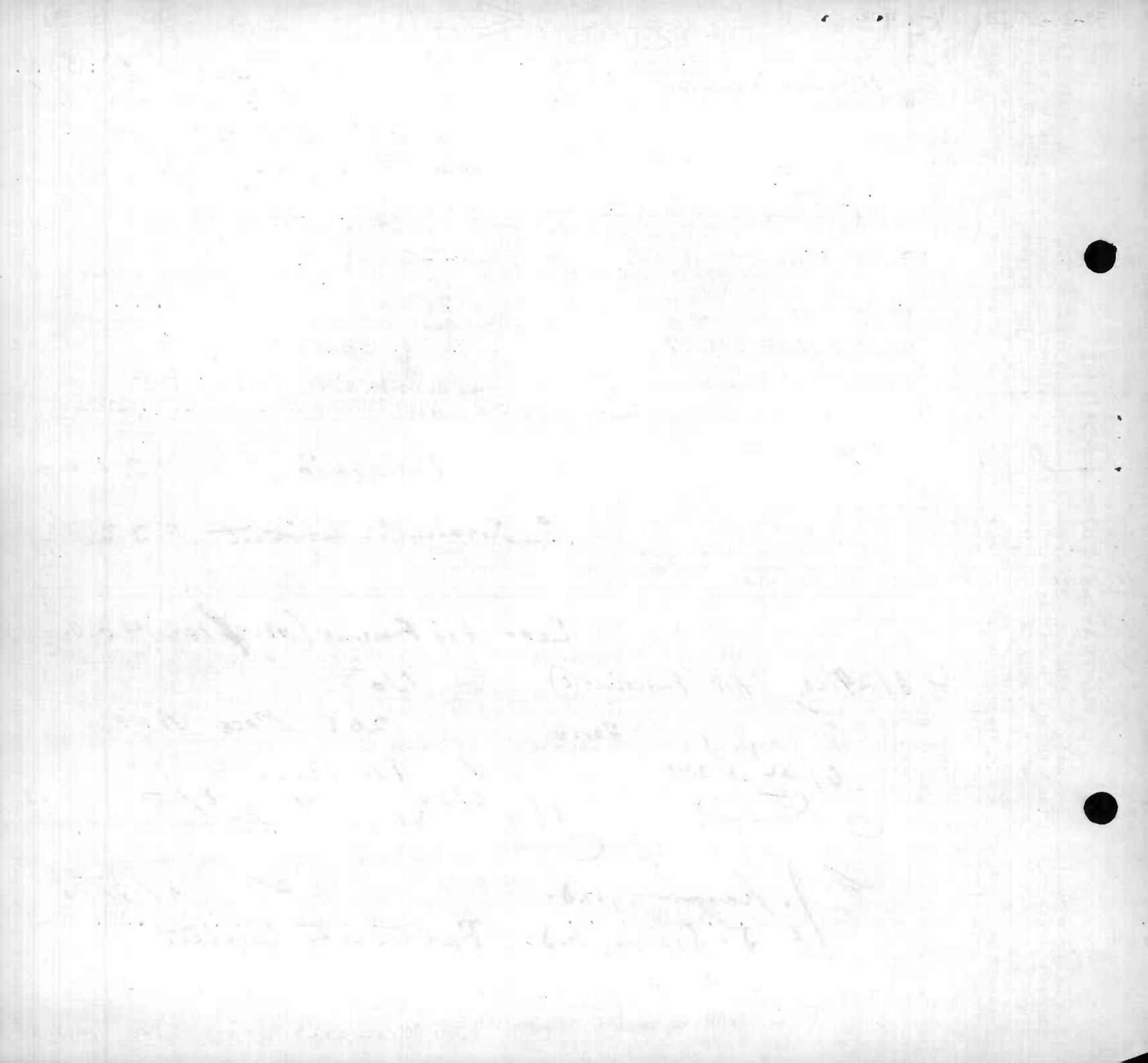
BIRTH NO. 67-05374		BALTIMORE CITY HEALTH DEPARTMENT		X NO. 68-8219	
1. NAME OF DECEASED (Type or Print) Timothy Hill		2. DATE AND HOUR OF DEATH 6 Aug 68 9:25 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY of MARYLAND HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO			53-00
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO	
13. FATHER'S NAME Donald Hill		14. MOTHER'S MAIDEN NAME PEARL Kimble		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT DONALD HILL ABOVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) OPERATIVE Hemorrhage ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Altered Venous Malformation of the brain		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 6 Aug 68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Altered Venous Malformation Brain Only		20A. AUTOPSY (Yes or No) (YES)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/23/68 19 to 6 August 68 19, that (I) (we) last saw the deceased alive on 6 Aug 68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R.M.H. Grody MD		23B. DATE SIGNED 6 Aug 68		23C. PHYSICIAN'S NAME (Type) DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/9/68		24C. NAME OF CEMETERY or CREMATORY GARDENS OF FAITH	
25A. DATE RECEIVED AUG 12 1968		25B. NAME OF REGISTRAR Club 2, Baltimore		25C. FUNERAL DIRECTOR 300 Mac... Cornelly Funeral Home	
24D. LOCATION BALTO. MD		24E. ADDRESS 1010 St Paul St. Balto			

(2315)

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HANNAH KENNEDY</b>		HANNAH N. KENNEDY		2. DATE AND HOUR OF DEATH <b>8/7/88 3:15 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND 21224</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>205 MACE AVE., 21221 005</b>							
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-7-88</b>		9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES FRANKLIN MC COY</b>				14. MOTHER'S MAIDEN NAME <b>MARY J. BARNETT</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>N</b>		16. SOCIAL SECURITY NO. <b>232-26-2683 J</b>		17. INFORMANT <b>RECORDS: BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVE., BALTO., MD. 21224</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b>				CAUSE OF DEATH A. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebrovascular accident</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>21 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>LECT Hip Fracture (neck of femur)</b>				B. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>331X II</b>		C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>42 days</b>	
19A. DATE OF OPERATION <b>6/24/88</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Hip Fracture (R)</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>205 MACE AVE.</b>			
21D. TIME OF INJURY (APPROX.) <b>6/24/88 3PM</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>PT. FELL.</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>6/24</b> 19 <b>88</b> to <b>8/7</b> 19 <b>88</b> , that (I) (we) last saw the deceased alive on <b>8/7</b> 19 <b>88</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>F. J. Scarpa, M.D.</b>				23B. DATE SIGNED <b>8/7/88</b>			
23C. PHYSICIAN'S NAME (Type) <b>F. J. SCARPA, M.D.</b>				23D. ADDRESS <b>4940 EASTERN AVE., BALTO., MD. 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24B. DATE <b>8/8/88</b>		24C. NAME OF CEMETERY or CREMATORY <b>JONES CHAPEL</b>		24D. LOCATION (City, town, or county) (State) <b>CEDAR BLUFF VA.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>Aug 12 1988</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>J. G. CONNELLY SONS</b>			
				ADDRESS <b>300 MACE</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT amend items 8, 12 per co g939 5-2-13 v				REG. NO. 68- 8221
<b>68- 8221</b>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>Salvatore Benveniga</b>		2. DATE AND HOUR OF DEATH <b>August 10, 1968</b> <span style="float: right;"><b>6:00 A.M.</b></span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>00 200 S Robinson Street</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1-02</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>200 S. Robinson</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 2/12/1880</b>	9. AGE (In years last birthday) <b>88</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>
12. CITIZEN OF WHAT COUNTRY? <b>Italy U.S.A.</b>		13. FATHER'S NAME <b>Vito Benveniga</b>		
14. MOTHER'S MAIDEN NAME <b>Antonia Rizzo</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>212-07-5736</b>		17. INFORMANT <b>Mrs. Antonina Benveniga</b> ADDRESS <b>200 S. Robinson Street</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>412.21</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>443X II</b>		CAUSE OF DEATH <b>Hypertensive cardiac - vascular disease - myocardial infarction</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>Feb 1965</b> to <b>Aug 10 1968</b> that (I) (we) last saw the deceased alive on <b>8/9 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Joseph R. Liberto</b>		23B. DATE SIGNED <b>8/11/68</b>		23C. PHYSICIAN'S NAME (Type) <b>JOSEPH R. LIBERTO</b>
23D. ADDRESS <b>3509 BAIT ST - BALTIMORE 21224 MD</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>8/13/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Stanislaus Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>Joseph N. Zannino - 263 S. Conkling Street</b>

CZ108 2/2/3/4/

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8222

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CADDIE GRIER

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

8

10

68

9:15 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

August

10

1968 9:15 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Balto.

YES ☒NO ☐

6. SEX

7. RACE

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

Female

Colored

9. DATE OF BIRTH

Jan 22, 1905

10. AGE (In years  
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.  
Months, Days, Hours, Min.

11. BIRTHPLACE (State or foreign country)

Charlotte, N.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

E. STREET AND NUMBER

617 Cumberland St.

13. FATHER'S NAME

Morris Grier

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Maggie Grier

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

Cicero Grier

ADDRESS

Charlotte NC

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)Hypertensive arteriosclerotic cardiovascular  
disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 10, 1968

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

Aug 13, 1968

24C. NAME OF CEMETERY or CREMATORY

York Memorial Park

24D. LOCATION

(City, town, or county)

(State)

Mecklenburg County, N C

25A. DATE REC'D BY HEALTH DEPT.

AUG 12 1968

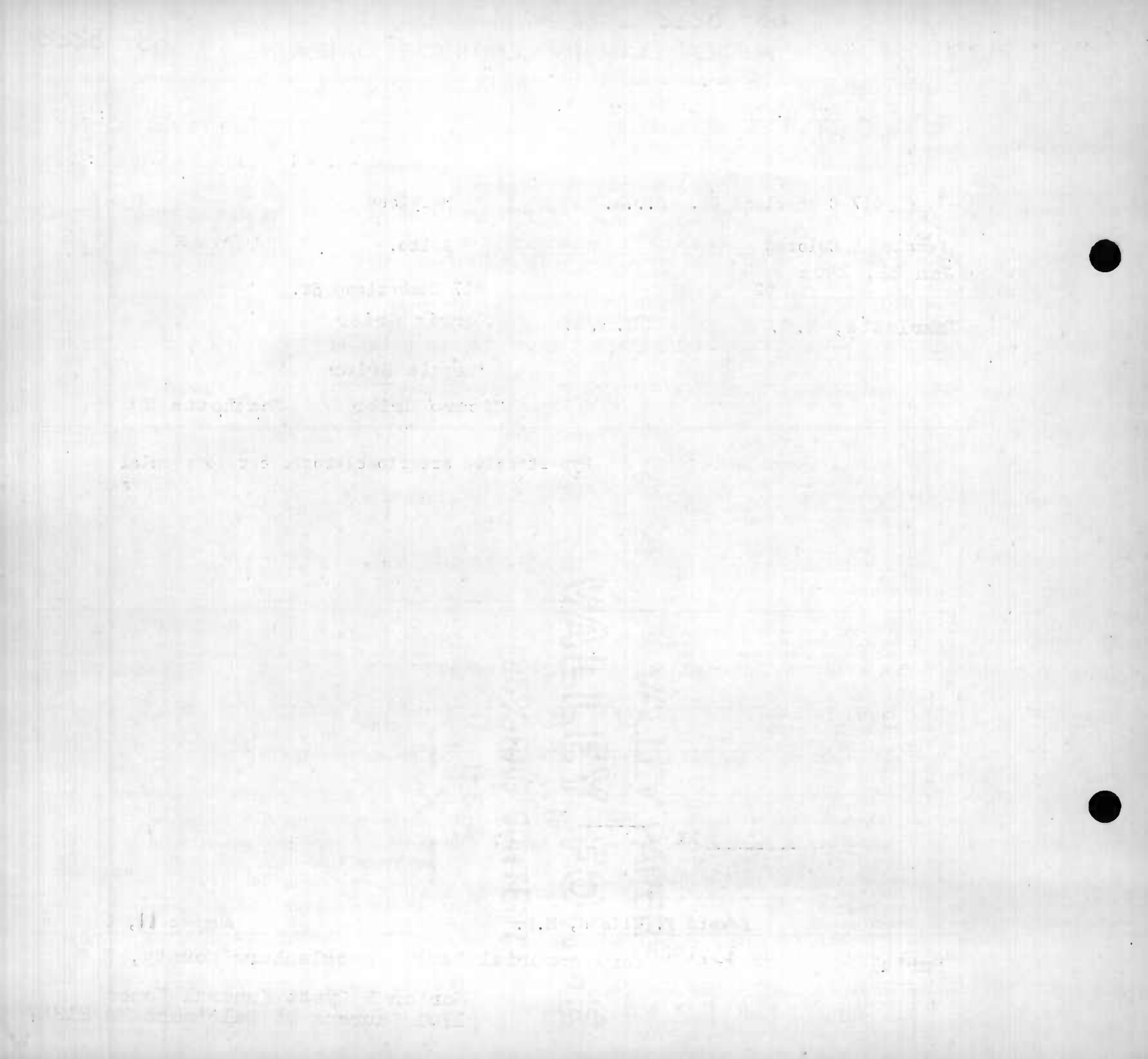
25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Morton &amp; Dyett Funeral Homes

1701 Laurens St Baltimore Md 21217



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8223

BIRTH NO.

## 1. NAME OF DECEASED

(Type or Print)

FRANKLYN

D. BINGLEY

2. DATE  
OF  
DEATHKnown ☐Estimated ☐

Month

Day

Year

Hour

July 18, 1968

7:28 P.

M.

## 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If not in hospital or institution, give street  
address or location)

37 PROVIDENT HOSPITAL

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

July 18, 1968

7:28 P.

M.

## 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

## 6. SEX

Male

## 7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

## C. CITY OR TOWN

Baltimore

## D. INSIDE CITY LIMITS?

YES ☐NO ☐

## 9. DATE OF BIRTH

4-23-39

10. AGE (In years  
last birthday)

29

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

## E. STREET AND NUMBER

1740 W. North Avenue

## 11. BIRTHPLACE (State or foreign country)

Canadys, S. Carolina

## 12. CITIZEN OF

WHAT COUNTRY?  
USA

## 13. FATHER'S NAME

Ben Bingley

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

PORTER

## 14B. KIND OF BUSINESS OR INDUSTRY

RESTAURANT

## 15. MOTHER'S MAIDEN NAME

Lena Mae Bingley (Poser)

## 16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)  
No

No

17. SOCIAL  
SECURITY NO.

248/56/9214

## 18. INFORMANT

## ADDRESS

Harvey Jones 1740 W. North Ave.

## 19. 420X I

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

Purulent Pericarditis

## (A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## (B)

DUE TO, OR AS A CONSEQUENCE OF:

## (C)

MEDICAL CERTIFICATION

432X II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

## 20A. DATE OF OPERATION

## 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

## 21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

## 22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

## 22F. HOW DID INJURY OCCUR?

## 23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 8, 1968

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

## 24B. DATE

8/13/68

## 24C. NAME of CEMETERY or CREMATORY

Red Banks Church Cem.

## 24D. LOCATION

(City, town, or county)

(State)

Colleton County, S. C.

## 25A. DATE REC'D BY HEALTH DEPT.

AUG 12 1968

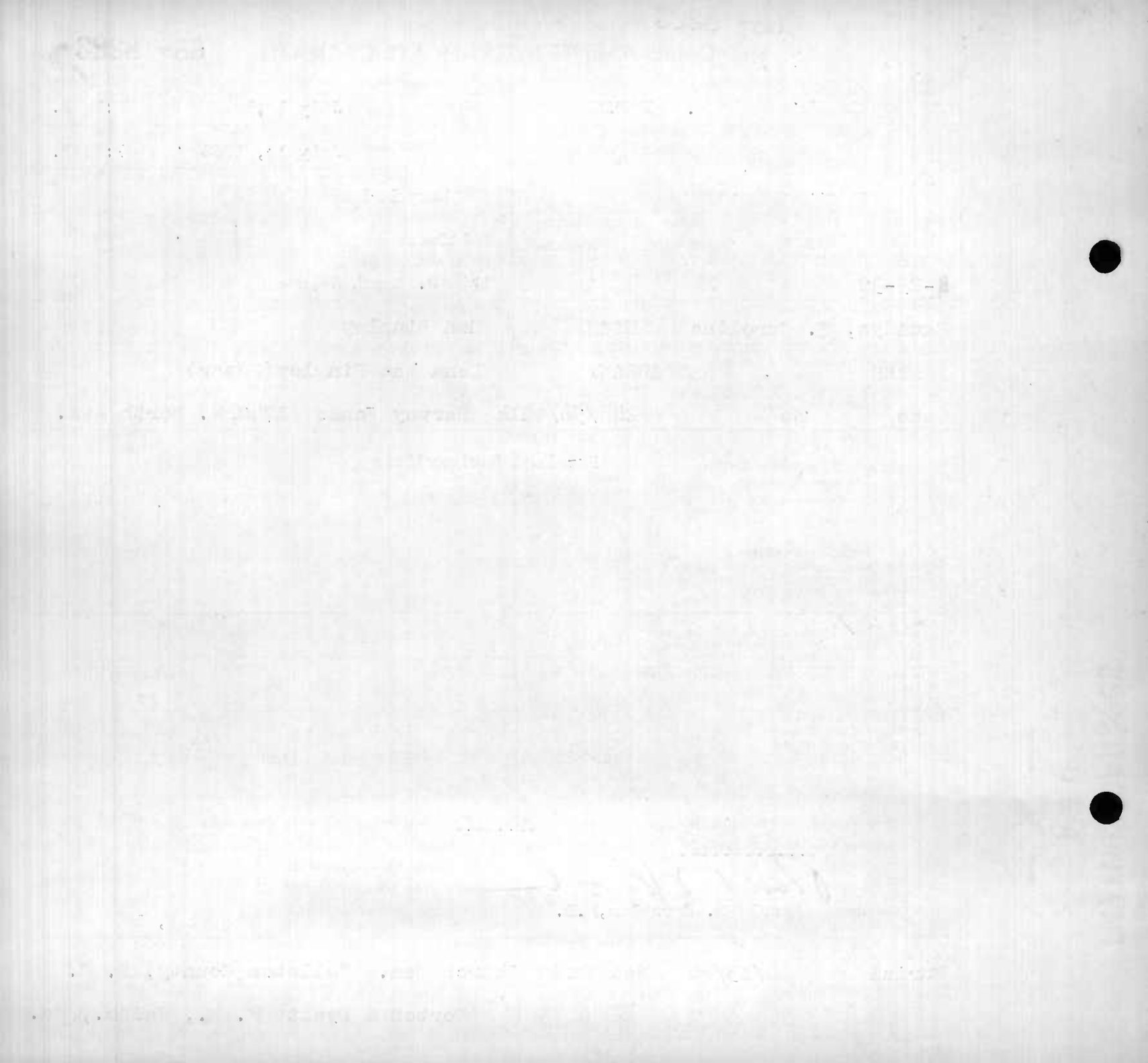
## 25B. NAME OF REGISTRAR

Robert E. Feltz, Jr.

## 25C. FUNERAL DIRECTOR

## ADDRESS

Morton &amp; Dyett F. H., Balto., Md.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 8224 CERTIFICATE OF DEATH

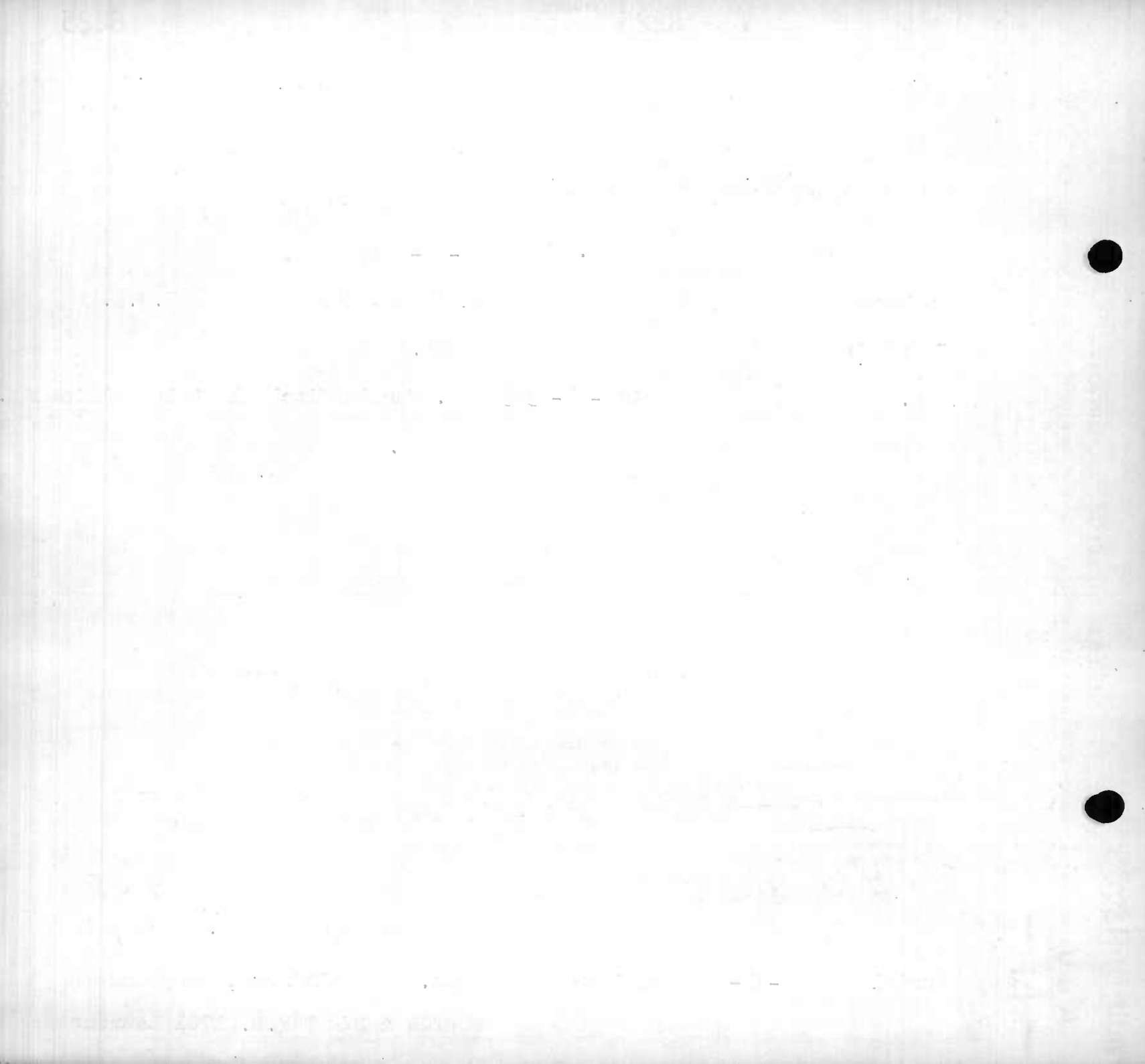
REG. NO. 68- 8224

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>REYNOLDS, SIGNORA</b>		2. DATE AND HOUR OF DEATH <b>8/9/68 11 AM</b>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 THE JOHNS HOPKINS HOSPITAL BALTIMORE MD 21205</b>				A. STATE <b>MD</b>		B. COUNTY	
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>2739 E. BIDDLE ST.</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-1-77</b>	9. AGE (In years last birthday) <b>90</b>	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Lynchburg, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MATTHEW EARKUMS</b>				14. MOTHER'S MAIDEN NAME <b>JULIA EARKUMS</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Ellis Reynolds</b>		ADDRESS <b>2739 E. Biddle</b>	
18. <b>486X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardio-Respiratory arrest to pneumonia</b>		<b>2<sup>o</sup> 11 AM</b>	
				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia</b>			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>493X II</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>August 5 1968</b> to <b>August 9 1968</b> , that (I) (we) last saw the deceased alive on <b>August 9 1968</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Edward D. Hunt Jr. M.D.</b>				23B. DATE SIGNED <b>8/9/68</b>		23C. PHYSICIAN'S NAME (Type) <b>Edward D. Hunt Jr. M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-13-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mount Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>A.A. Co., Maryland</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 12 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Garbure</b>		25C. FUNERAL DIRECTOR ADDRESS <b>MORTON &amp; DYETT F.H. 1701 Laurens St.</b>			

72-1-8

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

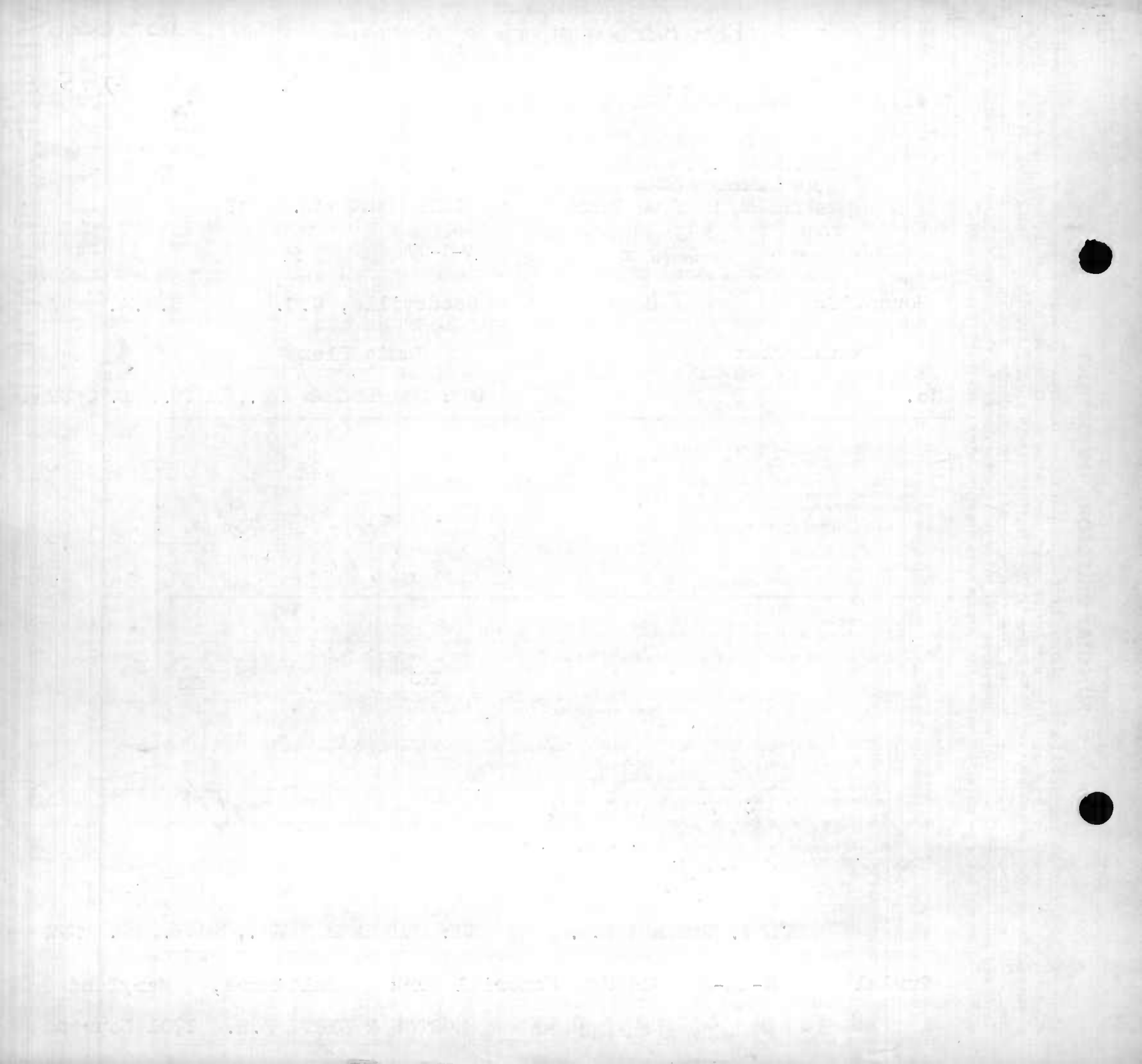
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Charles Henry Jones</i>		2. DATE AND HOUR OF DEATH <i>8-9-68 11:00 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>17-01</i>		5. CITY OR TOWN <i>Baltimore</i> INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>594 W. Biddle St.</i>	
6. SEX <i>M</i>	7. RACE <i>N</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH <i>11-10-1917</i>	10. AGE (In years last birthday) <i>50</i>	11. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>James Jones</i>		14. MOTHER'S MAIDEN NAME <i>UNK.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes.</i>		16. SOCIAL SECURITY NO. <i>214-14-0363</i>		17. INFORMANT ADDRESS <i>Mrs. Jurlin Mitchell 2018 Hollins St.</i>	
18. <i>379.21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Acute Pulmonary Embolism</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Chronic Obstructive Pulm Disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Cor Pulmonale</i>		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Chronic Obstructive Pulm Disease</i>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>327.2 II</i>					
19A. DATE OF OPERATION <i>8-27-68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>7-27-68</i> to <i>8-9-68</i> , that (I) (we) lost <u>saw</u> the deceased alive on <i>8-9-68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>W. Boddie</i>		23B. DATE SIGNED <i>8-9-68</i>		23C. PHYSICIAN'S NAME (Type) <i>W. Boddie</i>	
23D. ADDRESS <i>University of Maryland Hospital</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-14-68</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Baltimore Nat'l Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE RECD BY HEALTH DEPT. <i>AUG 12 1968</i>	
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>MORTON &amp; DYETT F.H.</i>		25D. ADDRESS <i>1701 Laurens</i>	



## FUNERAL DIRECTOR: IMPORTANT

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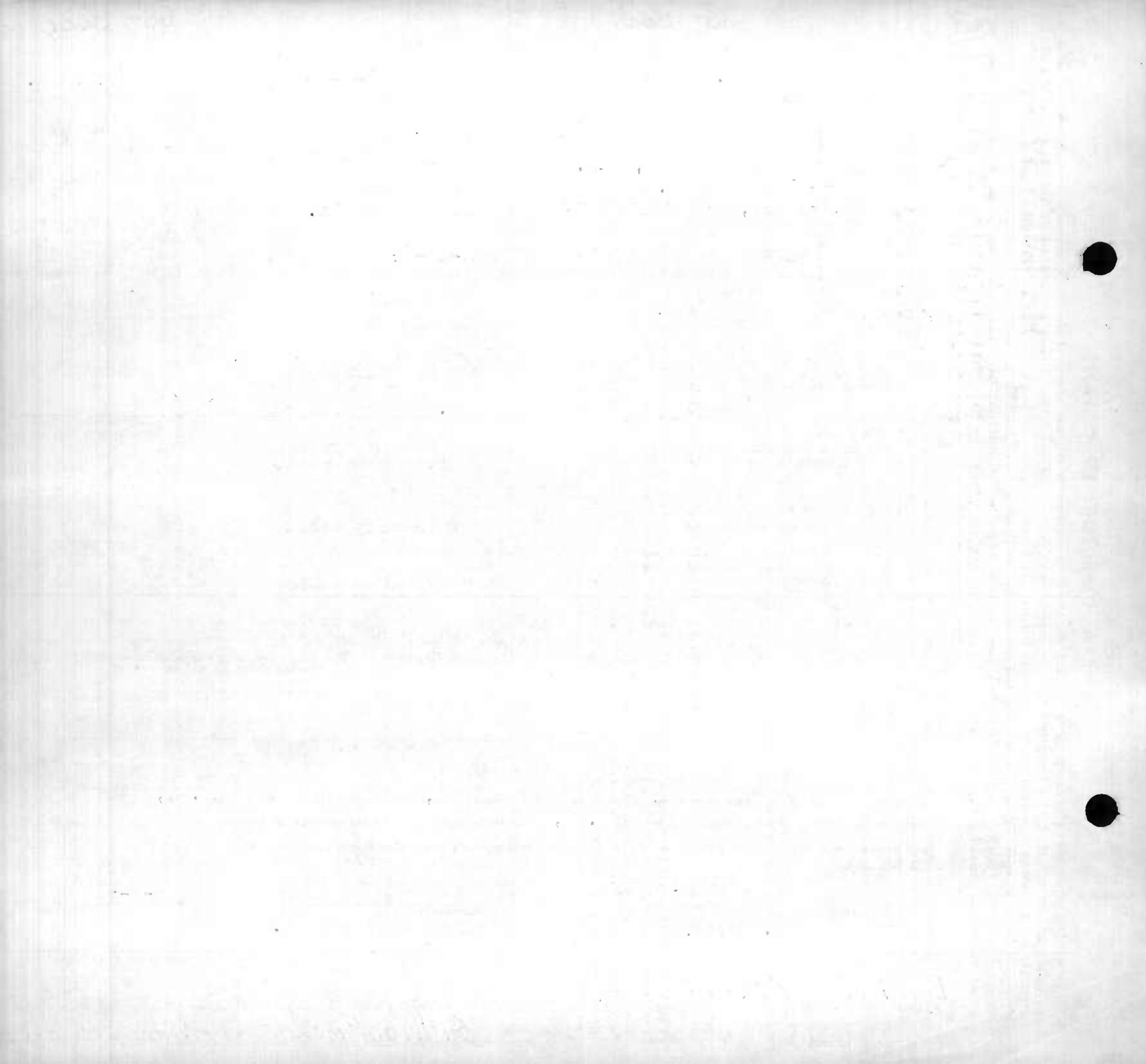
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8226	
P-520		68- 8226		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Louise Pinnix		2. DATE AND HOUR OF DEATH 8/8/68 10:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 2026 LINDEN AVE. 21217	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-1-09	9. AGE (In years lost birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Reedsville, N.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel Flax		14. MOTHER'S MAIDEN NAME Mamie Flax	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.		17. INFORMANT BCH: 4940 EASTERN AVE., BALTO., MD. 21224	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 609X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Septicemia (B) Urinary Tract Infection DUE TO, OR AS A CONSEQUENCE OF: Chronic Uremia (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days > 10 yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/2 1968 to 8/8 1968, that (I) (we) lost saw the deceased alive on 8/8 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Robert A. Rosenbaum M.D.		23B. DATE SIGNED 8/8/68		23C. ADDRESS BCH: 4940 EASTERN AVE., BALTO., MD. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-12-68		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. AUG 12 1968		24F. NAME OF REGISTRAR Robert E. Taylor	
24G. FUNERAL DIRECTOR MORTON & DYETT F.H.		24H. ADDRESS 1701 Laurens		24I. DATE OF DEATH 8/8/68	



# FUNERAL DIRECTOR: IMPORTANT

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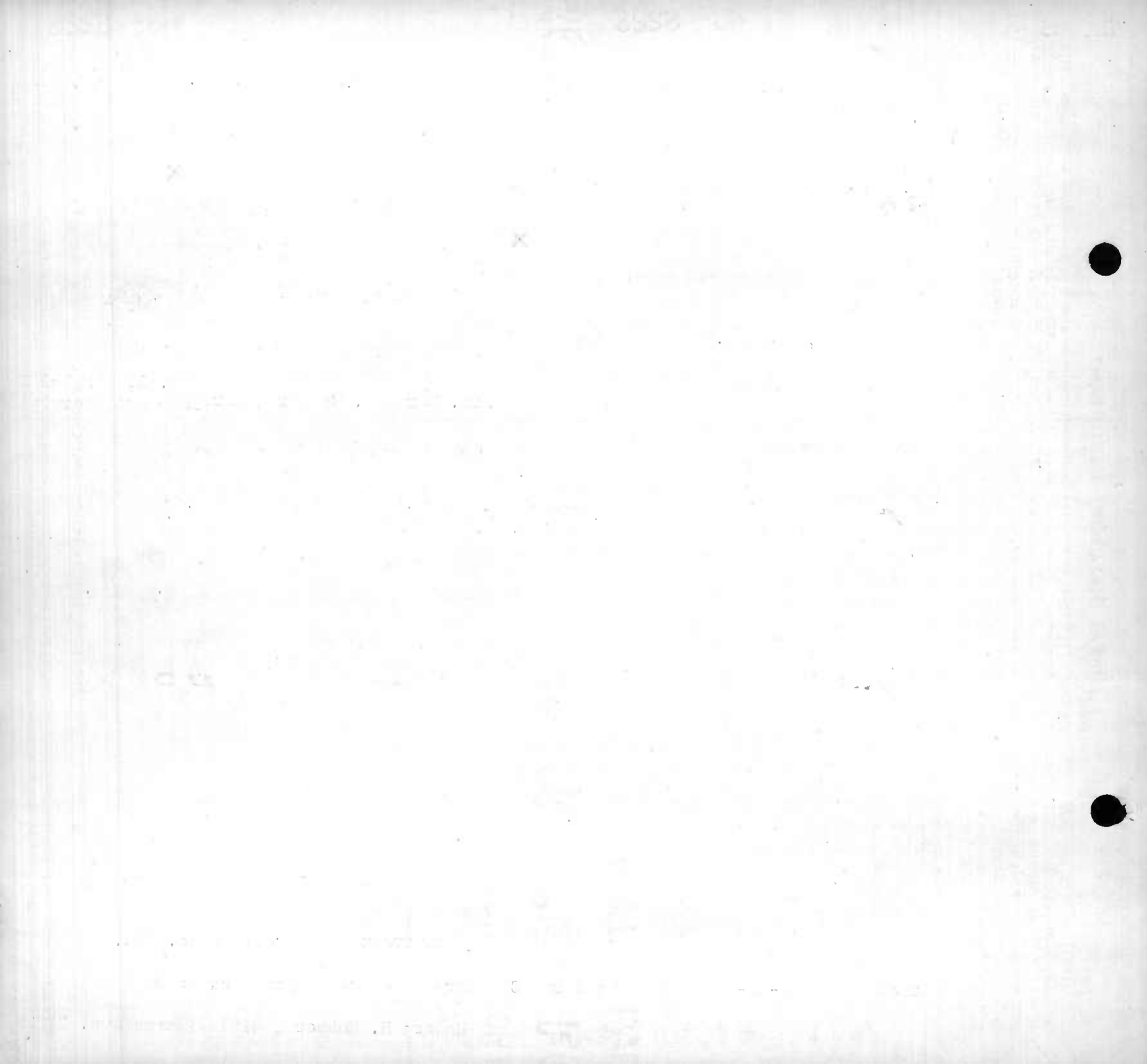
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8227	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) William C. Keene		2. DATE AND HOUR OF DEATH 8-8-68 9:10 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-01			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital, Inc. 1514 Division St. Baltimore, Maryland 21217		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1214 Mosher St.					
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-16-98	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Chem. Industry		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME William A. Keene		14. MOTHER'S MAIDEN NAME Mary E. Spedden			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Aretta Mrs. Retta Dunnock (Sister) ADDRESS Same	
18. 485X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchopneumonia (B) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 25, 1968 19 to Aug. 8, 1968 19, that (I) (we) lost saw the deceased alive on Aug. 8, 1968 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Humbert H. H. M.D.		23B. DATE SIGNED 8-9-68			
23C. PHYSICIAN'S NAME (Type) H. Certeza		23D. ADDRESS 1514 Division St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-12-68		24C. NAME OF CEMETERY or CREMATORY Smithville Cem.	
24D. LOCATION (City, town, or county) (State) Smithville Md					
25A. DATE REC'D BY HEALTH DEPT. AUG 13 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR 1011-13 ADDRESS Sullivan Funeral Home - N. Arlington Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8228	
<div style="display: flex; justify-content: space-between;"> <span>68- 8228</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>EWING GRACE MARY</i>			2. DATE AND HOUR OF DEATH <i>Aug 9 1968 3 30 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>20-05</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland Hospital</i> <i>38</i>			C. CITY OR TOWN <i>MILLENDALE</i> INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>440 WILKINSON AVE</i> <i>BALTIMORE MD 21223</i>		
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-1-07</i>	9. AGE (In years last birthday) <i>61</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nurse</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>USA, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>LLOYD EWING (de)</i>		14. MOTHER'S MAIDEN NAME <i>MARY JENNINGS (de)</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Marie E. Ganzermiller</i> ADDRESS: <i>Rt. 1, Box 243 B Pasadena, Maryland</i>	
18. <i>395701</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <i>POSS. CORONARY EMBOLEZM</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>DURING OPEN HEART SURGERY</i> <i>CARCINIC RHEUMATIC, AORTIC</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>STROKE</i> (C) _____		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>410X II</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <i>Aug 9-68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Rheumatic heart dis.</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>HAS BEEN</i>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>8-1-68</i> to <i>8-9-68</i> , that (I) (we) last saw the deceased alive on <i>8-9-68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>M. H. Gonzalez</i>			23B. DATE SIGNED <i>Aug 9-68</i>		23C. PHYSICIAN'S NAME (Type) <i>M. H. Gonzalez</i>
23D. ADDRESS <i>University Hospital, Balto., Md.</i>			23E. DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-13-1968</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 13 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Howard H. Hubbard</i>	
25D. ADDRESS <i>4107 Wilkens Ave. 21229</i>		25E. (State)			



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J-250

68- 8229 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8229

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

WILLIAM

JACKSON

2. DATE OF DEATH

Known ☒ Estimated ☐

Month

Day

Year

Hour

August 11, 1968

5:45 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

2204 W. Saratoga Street

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

August 11, 1968

5:45 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☒ NO ☐

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

March 2, 1912

10. AGE (In years lost birthday)

56

If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.

2 1 1 1

E. STREET AND NUMBER

2204 W. Saratoga Street

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William J. Jackson Sr.

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Machine Operator

14B. KIND OF BUSINESS OR INDUSTRY

American Coat and Suit Co.

15. MOTHER'S MAIDEN NAME

Cora Carrington

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

17. SOCIAL SECURITY NO.

220-09-0163

18. INFORMANT

ADDRESS

Mrs. Louise Jackson, 2204 W. Saratoga St.

19. 444.2

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Infarction of Small Intestine due to

(A) IMMEDIATE CAUSE

~~HEAVY COAGULATED BLOOD~~ Occlusion of Mesenteric Artery

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

570.2 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Arteriosclerotic Cardiovascular Disease

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/12/68

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-15-68

24C. NAME OF CEMETERY or CREMATORY

Baltimore, National

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 13 1968

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Charles E. W. 802 Madison Ave.

ADDRESS

DO NOT WRITE IN THESE SPACES

1 - 1 - 1

— *[Signature]*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 68- 8230 CERTIFICATE OF DEATH

REG. NO. 68- 8230

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>White Barbara</b>		2. DATE AND HOUR OF DEATH <b>8.9.68 6.15 AM.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>20-03</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Franklin Square Hospital</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>F</b>			6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>12-20-24</b>			9. AGE (in years last birthday) <b>44 yrs</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			13. FATHER'S NAME <b>Joseph FEFEL</b>		
14. MOTHER'S MAIDEN NAME <b>Helen Romm</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>none</b>		
16. SOCIAL SECURITY NO. <b>?</b>			17. INFORMANT <b>309 S. Payson St. BALTO. Md.</b> <b>MR. DONALD E. WHITE SR.</b>		
18. <b>486X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19. <b>493X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8.5.68</b> 19 to <b>8.9</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8.9.68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M. Afzal MD</b>			23B. DATE SIGNED <b>8-9-68</b>		23C. PHYSICIAN'S NAME (Type) <b>M. AFZAL MD</b>
23D. ADDRESS <b>100 N Calhoun Street</b>			24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>Aug. 13, 1968</b>			24C. NAME OF CEMETERY or CREMATORY <b>Balto. National Cem.</b>		
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>			25A. DATE REC'D BY HEALTH DEPT. <b>AUG 13 1968</b>		
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>			25C. FUNERAL DIRECTOR <b>G. Truman Schwab</b>		
ADDRESS <b>3512 Frederick</b>					

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FUNERAL DIRECTOR: IMPORTANT

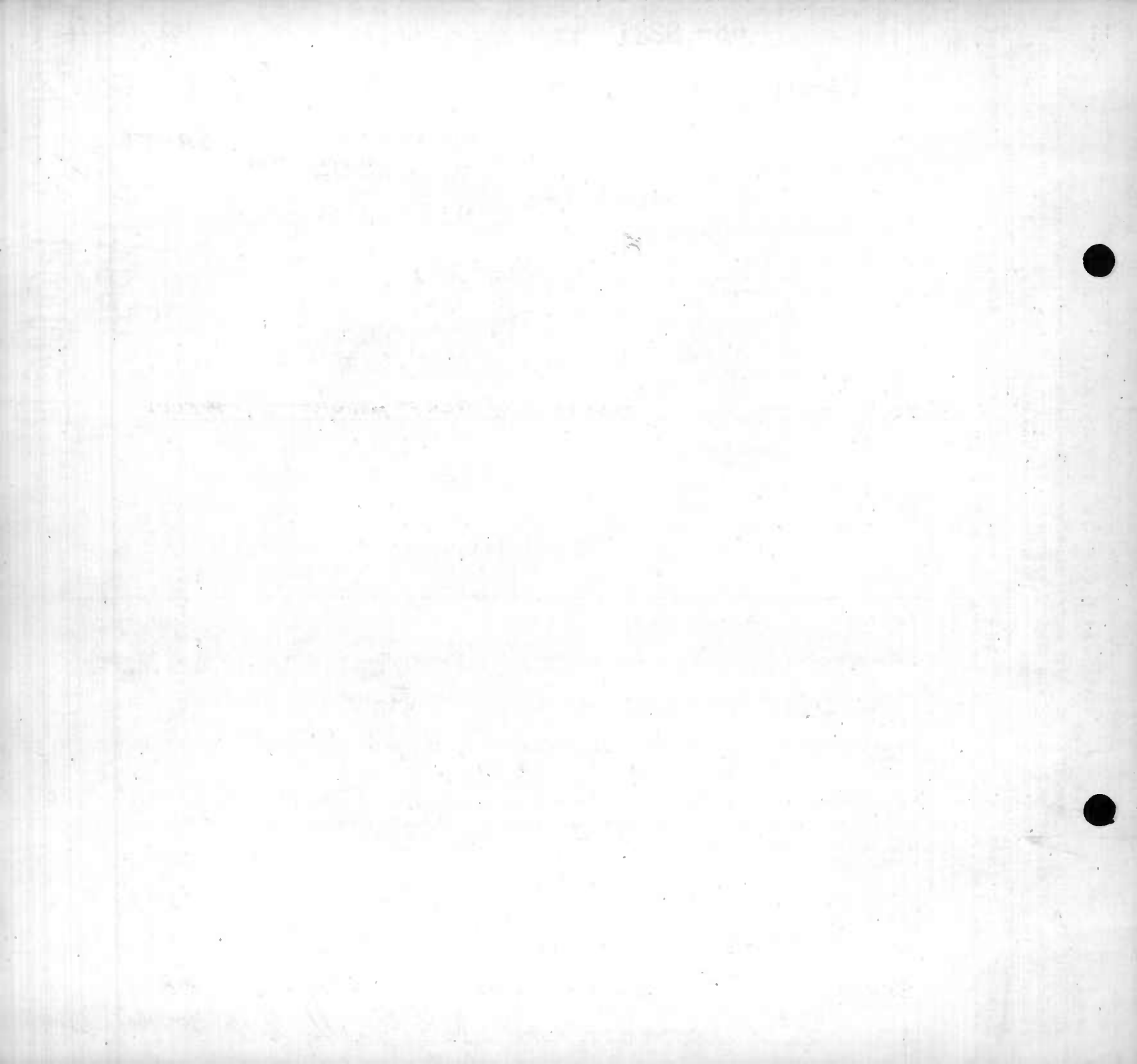
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8231 CERTIFICATE OF DEATH

REG. NO.

68- 8231

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CLAUDE H. HOUCK</b>		2. DATE AND HOUR OF DEATH <b>AUG. 9, 1968 5:15 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO</b>		C. CITY OR TOWN <b>MIDDLE RIVER</b> INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>NORTH CHARLES GENERAL HOSPITAL</b> <b>49</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>113 Compass Road</b> <b>53.00</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6/3/27</b>	9. AGE (In years last birthday) <b>41</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ROOFER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SELF Employed</b>		11. BIRTHPLACE (State or foreign country) <b>N.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>CECIL E. HOUCK</b>		14. MOTHER'S MAIDEN NAME <b>MUNSIE Connard</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>246-28-2324</b>		17. INFORMANT <b>GARY HOUCK</b> ADDRESS <b>ABOVE</b>	
18. <b>571.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cirrhosis, liver</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. <b>581.0 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
19A. DATE OF OPERATION <b>5/8/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>yes</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Aug. 8</b> 19 <b>68</b> to <b>Aug. 9</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Aug. 9</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Sharon B. Paulino M.D.</b>		23B. DATE SIGNED <b>8/9/68</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. I. BECK</b> M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/12/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>BEL AIR MEM.</b>	
24D. LOCATION (City, town, or county) (State) <b>BELAIR MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>	
25C. FUNERAL DIRECTOR <b>J. M. Caimely, Inc.</b>		25D. ADDRESS <b>300 Main Ave.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

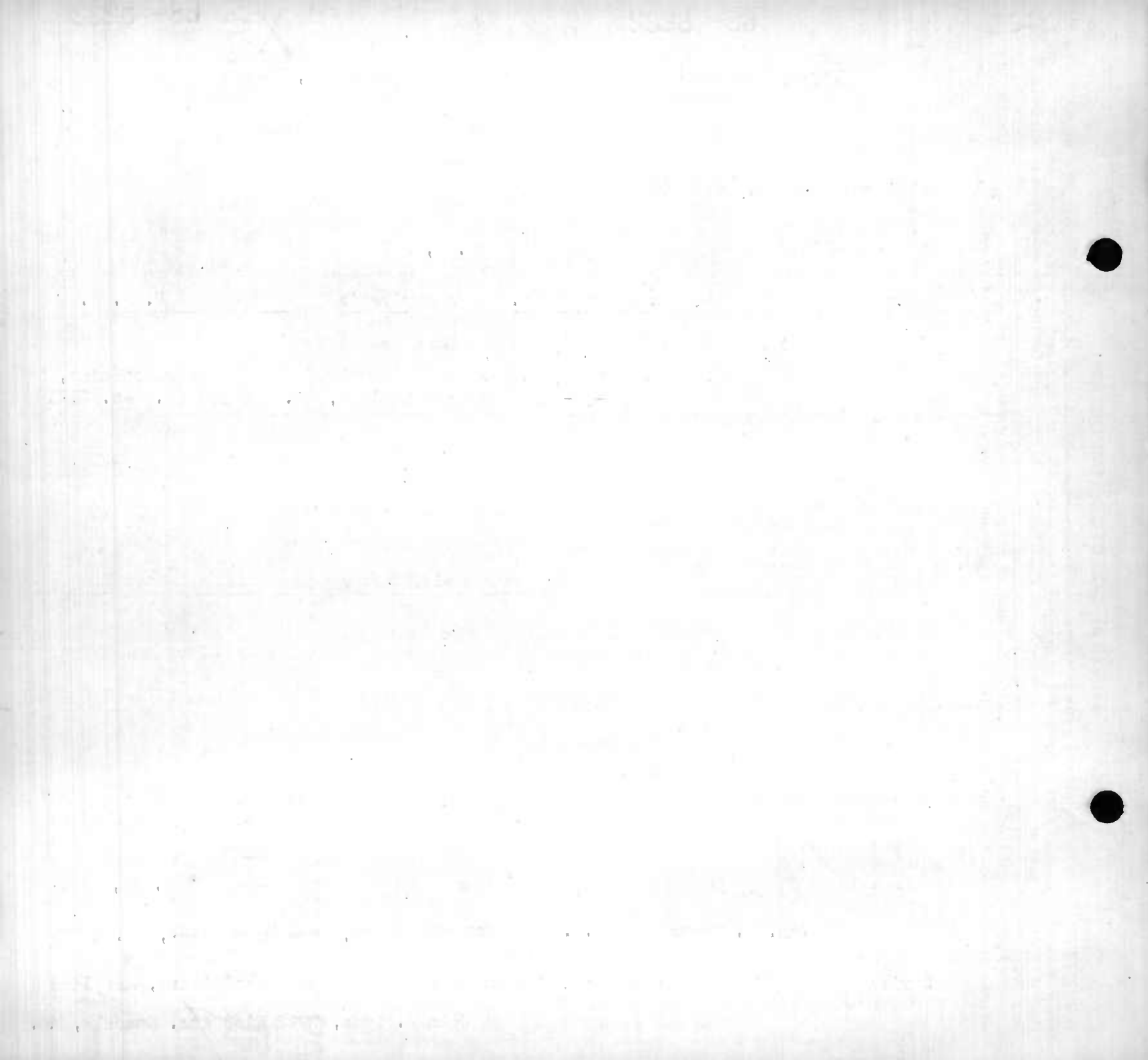
68- 8232

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68- 8232

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Clifford Madison</b>		2. DATE AND HOUR OF DEATH <b>August 9, 1968</b>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Baltimore City Hospital (DOA)</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> <b>53-00</b>			
				C. CITY OR TOWN <b>Sparrows Point</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>Route #10 Bet Cuckold Road</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 2, 1910</b>	9. AGE (In years lost birthday) <b>58</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Frederick Madison</b>				14. MOTHER'S MAIDEN NAME <b>Huma Newdeffer</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>213-09-4339</b>		17. INFORMANT (Brother) <b>Sparrows Point, Leonard Madison, Rt. #10 Box 66. Md. 21219</b>			
18. <b>4123 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerosis Ht. Disease</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerosis Ht. Disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerosis</b> (C) <b>Arteriosclerosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>1 yr</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>422.1 II</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>6-1-1968</b> to <b>8-2-1968</b> , that (I) (we) last saw the deceased alive on <b>7-26-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Jas. T. Means</b>				23B. DATE SIGNED <b>Aug. 12, 1968</b>		23C. PHYSICIAN'S NAME (Type) <b>Jas. T. Means M.D.</b>	
				23D. ADDRESS <b>520 "B" Street, Sparrows Point, Md. 21219</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/13/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE RECEIVED <b>AUG 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-412		68-8233		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		68-8233			
BIRTH NO.					1. NAME OF DECEASED (Type or Print) <b>George T. Phelps</b>						
2. DATE AND HOUR OF DEATH <b>8/10/68</b>					3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>GEORGE T. PHELPS</b>						
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>26-05</b>					5. FULL NAME OF HOSPITAL OR INSTITUTION <b>BALT. CITY HOSPITALS</b> 4940 Eastern Ave., Balto., Md. 21224						
6. CITY OR TOWN <b>BALTIMORE</b>					7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
8. STREET AND NUMBER <b>507 RAPPOLLA STREET</b>					9. 21224						
15. SEX <b>Male</b>		16. RACE <b>White</b>		17. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		18. DATE OF BIRTH <b>11-23-05</b>		19. AGE (In years lost birthday) <b>62</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Packer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Howard Medical &amp; Drug Co.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>GEORGE Eugene Phelps</b>			
14. MOTHER'S MAIDEN NAME <b>DAISY MASTER</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-07-9428</b>		17. INFORMANT <b>BCH: 4940 EASTERN AVE., BALTO., MD. 21224</b>		18. WIFE <b>SA</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>44091</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>45010 II</b>					CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Acute RENAL FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>OPERATIVE COMPLICATION</b> (B) <b>CRUSH INJURY SYNDROME</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>SEVERE ASVD</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION <b>8/6/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>HERICHTE SYNDROME</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <b>7/31</b> 19 <b>68</b> to <b>8/10</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/10</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>R. Hyden</b>					23B. DATE SIGNED <b>8/10/68</b>		23C. PHYSICIAN'S NAME (Type) <b>Ralph Hyden M.D.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>8/14/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mount Carmel Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		
25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 13 1968</b>					25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>John J. Duda</b>		25D. ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>		

10/31/68 - Crush injury syndrome not  
Traumatic but due to severe ASVD -  
Information from BCT Record Room -  
Phone call - ge.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 8234 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 8234

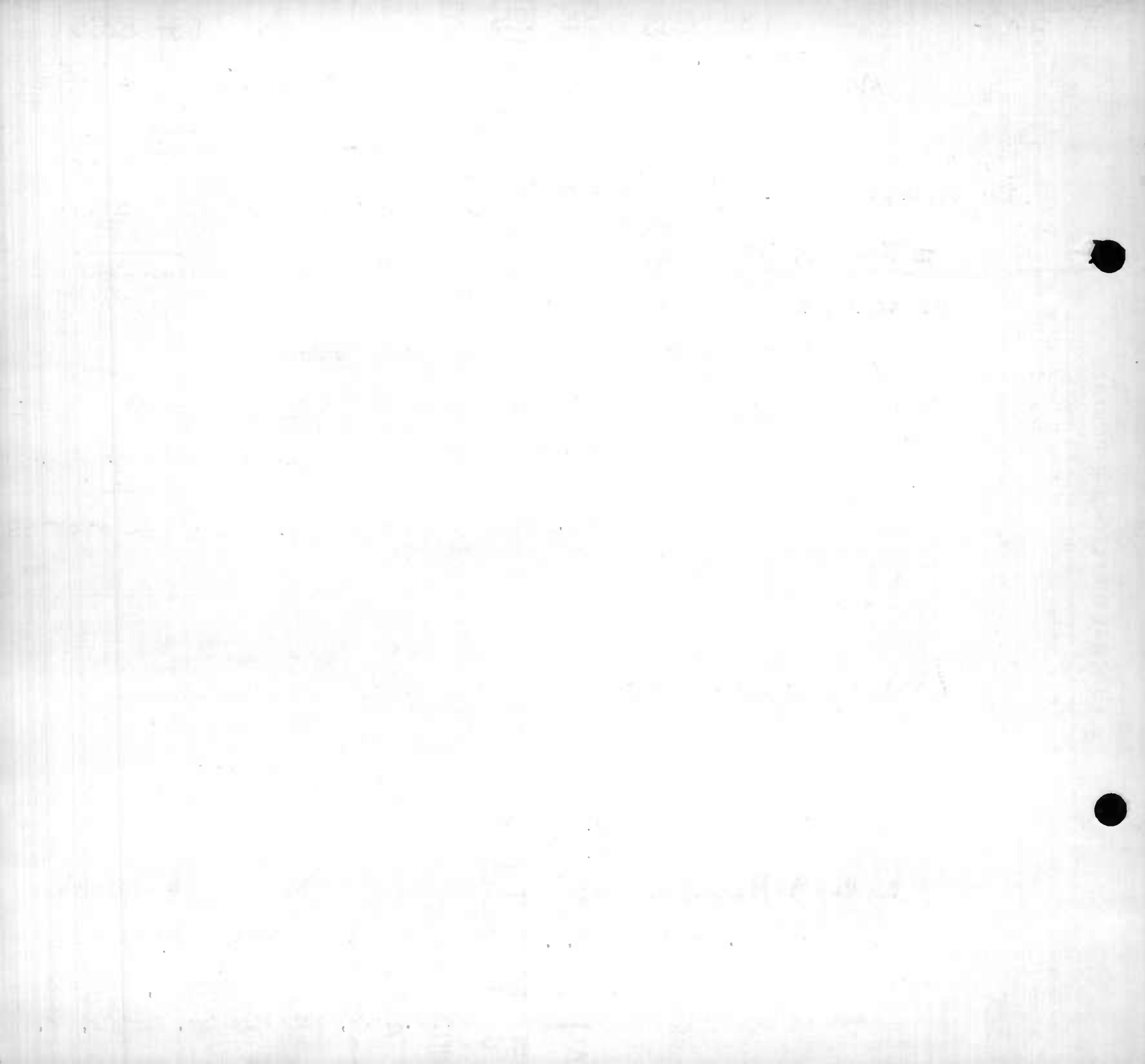
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Helwig Franklin</i>		2. DATE AND HOUR OF DEATH <i>8-10-'68</i>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hospital</i> <i>South Baltimore General Hospital</i>				C. CITY OR TOWN <i>Dundalk</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <i>1764 Brookview Rd.</i>			
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-17-01</i>	9. AGE (In years last birthday) <i>67</i>	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Baltimore City Police Department</i>			11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>Andrew Helwig</i>			14. MOTHER'S MAIDEN NAME <i>Anna Haberkorn</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>216-28-7202</i>		17. INFORMANT (Wife) <i>Mrs. Johanna Helwig, 1764 Brookview Rd.</i>		
18. <i>490X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Arterio Sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Cor Pulmonale - Chron. O.S.D.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>10 yrs</i> <i>10 yrs</i>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>501X II</i>							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) lost saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>John R. Gelbert, Jr., MD.</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8/10/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>John R. Gelbert</i>				23D. ADDRESS <i>South Baltimore General Hospital</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/14/68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE RECEIVED BY HEALTH DEPT. <i>AUG 15 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR ADDRESS <i>John J. Duda, 7922 Wise Ave. Dundalk, Md.</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

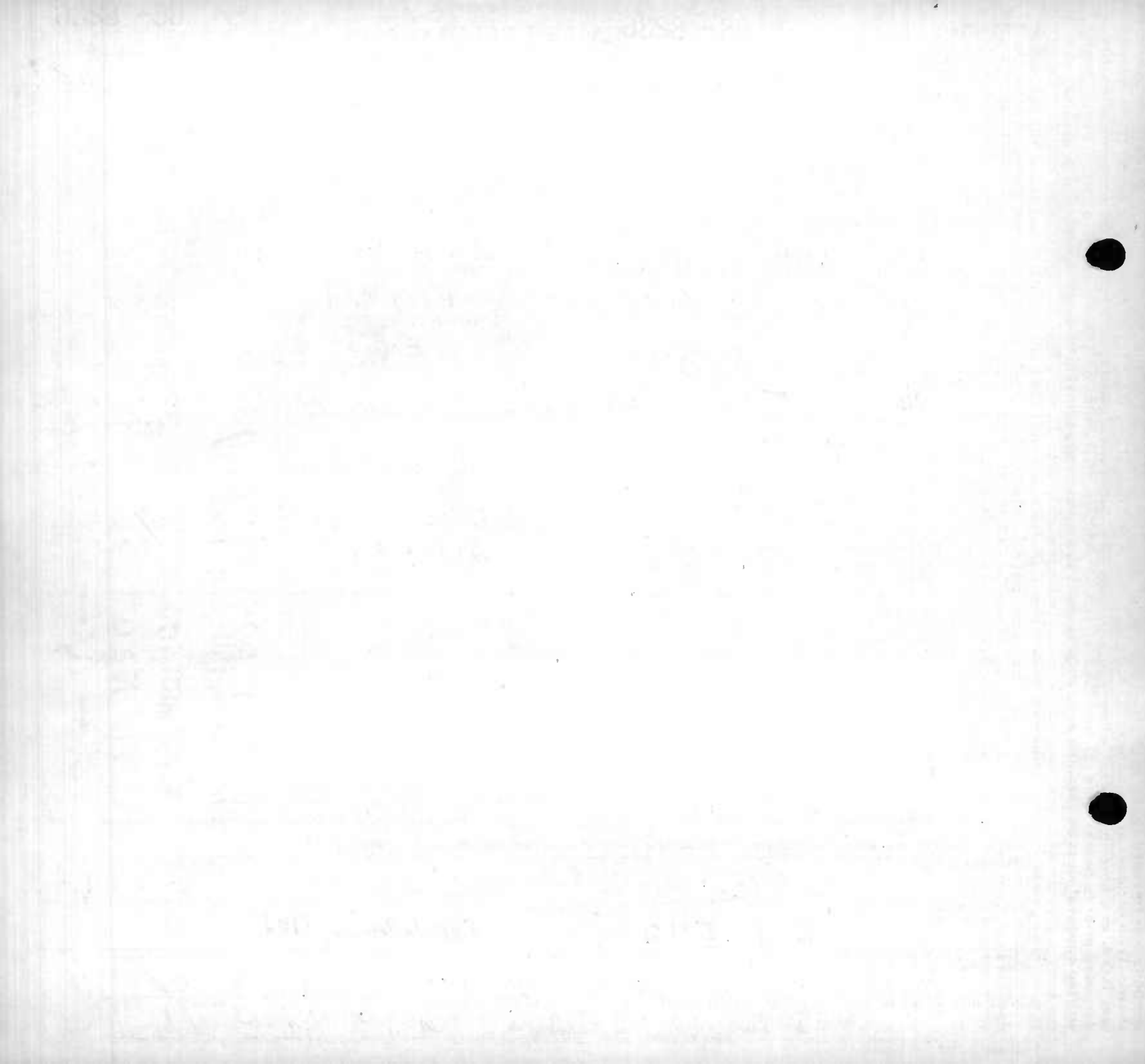
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-8235
<b>BIRTH NO.</b> 1. NAME OF DECEASED (Type or Print) <b>MARGARET L. PETERS</b>		<b>CERTIFICATE OF DEATH</b> 2. DATE AND HOUR OF DEATH <b>8-10-68 6:55A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND GENERAL HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>Edgemere</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>2132 LODGE FARM RD. 21219</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOUSE WIFE</b>		
13. FATHER'S NAME <b>Harry Mussellman</b>		14. MOTHER'S MAIDEN NAME <b>NELLIE Lockard</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-01-3853</b>		
17. INFORMANT <b>JOHN PETERS</b>		ADDRESS <b>- HUSBAND - SAME</b>		
18. <b>225.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>223X II</b>		CAUSE OF DEATH <b>POST OP BRAIN SWELLING</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  <b>EXCISION OF MENINGIOMA</b> (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)		
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>223X II</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>  <b>2 MONTHS</b>		
19A. DATE OF OPERATION <b>8-8-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Excising of frontal meningioma</b>		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>At Work</b>		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>Aug 10, 1968</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR? <b>At Work</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>At Work</b>		
22. I certify that (I) (this hospital) attended the deceased from <b>July 26, 1968</b> to <b>Aug 10, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 10, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Charles S. Harrison, M.D.</b>				23B. DATE SIGNED <b>8-10-68</b>
23C. PHYSICIAN'S NAME (Type) <b>Charles S. Harrison M.D.</b>		23D. ADDRESS <b>MARYLAND GENERAL HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/13/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Parkwood Cemetery</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 13 1968</b>		
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">68- 8236</span>	
BIRTH NO. <span style="float: right;">68- 8236</span> <b>CERTIFICATE OF DEATH</b>					
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <i>Robert S. Blizzard</i>		
2. DATE AND HOUR OF DEATH <i>Aug. 8, 1968</i> <span style="float: right;"><i>11:15 P.M.</i></span>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>4430 MARBLE HALL Road</i> <i>00</i>			A. STATE <i>Md.</i> B. COUNTY <i>-</i>		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			D. STREET ADDRESS (If rural, give location) <i>4430 MARBLE HALL Rd.</i>		
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>June 14, 1904</i>	9. AGE (In years last birthday) <i>64</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Automobile</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>George A. Blizzard</i>			14. MOTHER'S MAIDEN NAME <i>Emma Gibson</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-12 3265</i>	17. INFORMANT <i>Mrs. Jessica Blizzard</i>		ADDRESS <i>Baltimore, Md.</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>443 X II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO <i>acute heart failure</i> (B) DUE TO <i>Hypertensive Heart Disease</i> <i>A.I.S.C.V.D.</i> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> <i>9 yrs</i>
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <i>-</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>-</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>-</i>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>-</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>-</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>1963</i> to <i>8/9</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>8/8</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>W. J. Elin</i>				23B. DATE SIGNED <i>8/9/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>W. J. Elin</i>		23D. ADDRESS M.D. <i>Randallstown, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>8-11-68</i>	24C. NAME OF CEMETERY or CREMATORY <i>Wesley Freedom Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Sylasville, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 13 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Finkbeiner</i>		25C. FUNERAL DIRECTOR <i>Harry W. Haight</i>	
				ADDRESS <i>Sylasville, Md.</i>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8237

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LEO WEISENGOFF</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>August 9, 1968</b>		Hour <b>8:30 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>August 9, 1968</b>		Hour <b>8:30 A.M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>25-04</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. DATE OF BIRTH <b>1/10/1913</b>		10. AGE (In years lost birthday) <b>55</b>		E. STREET AND NUMBER <b>905 Nottingham Road</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Peter Mathew Weisengoff</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Superintendent</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Clothing Industry</b>		15. MOTHER'S MAIDEN NAME <b>Agatha Martha Mazeika</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>212-09-6784</b>		18. INFORMANT ADDRESS <b>Agnes Margaret E. Weisengoff</b>	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>August 9, 1968</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/13/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Balto National</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto Md.</b>		24E. FUNERAL DIRECTOR <b>Farley Carrough Funeral Home</b>		24F. ADDRESS <b>6601 Frederick Ave.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Farley Carrough Funeral Home</b>	

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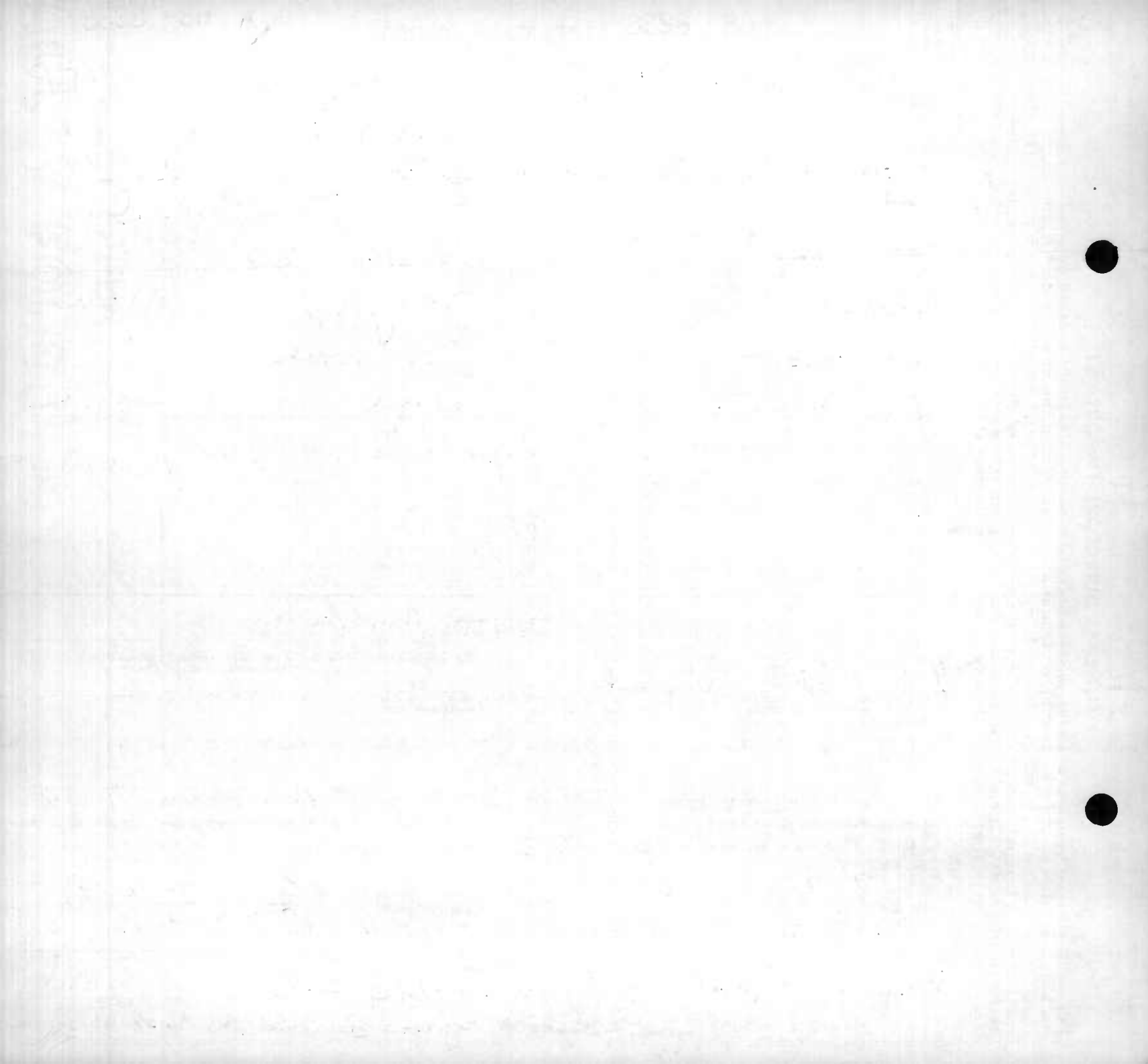
10-25-50

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8238 CERTIFICATE OF DEATH

REG. NO. 68- 8238

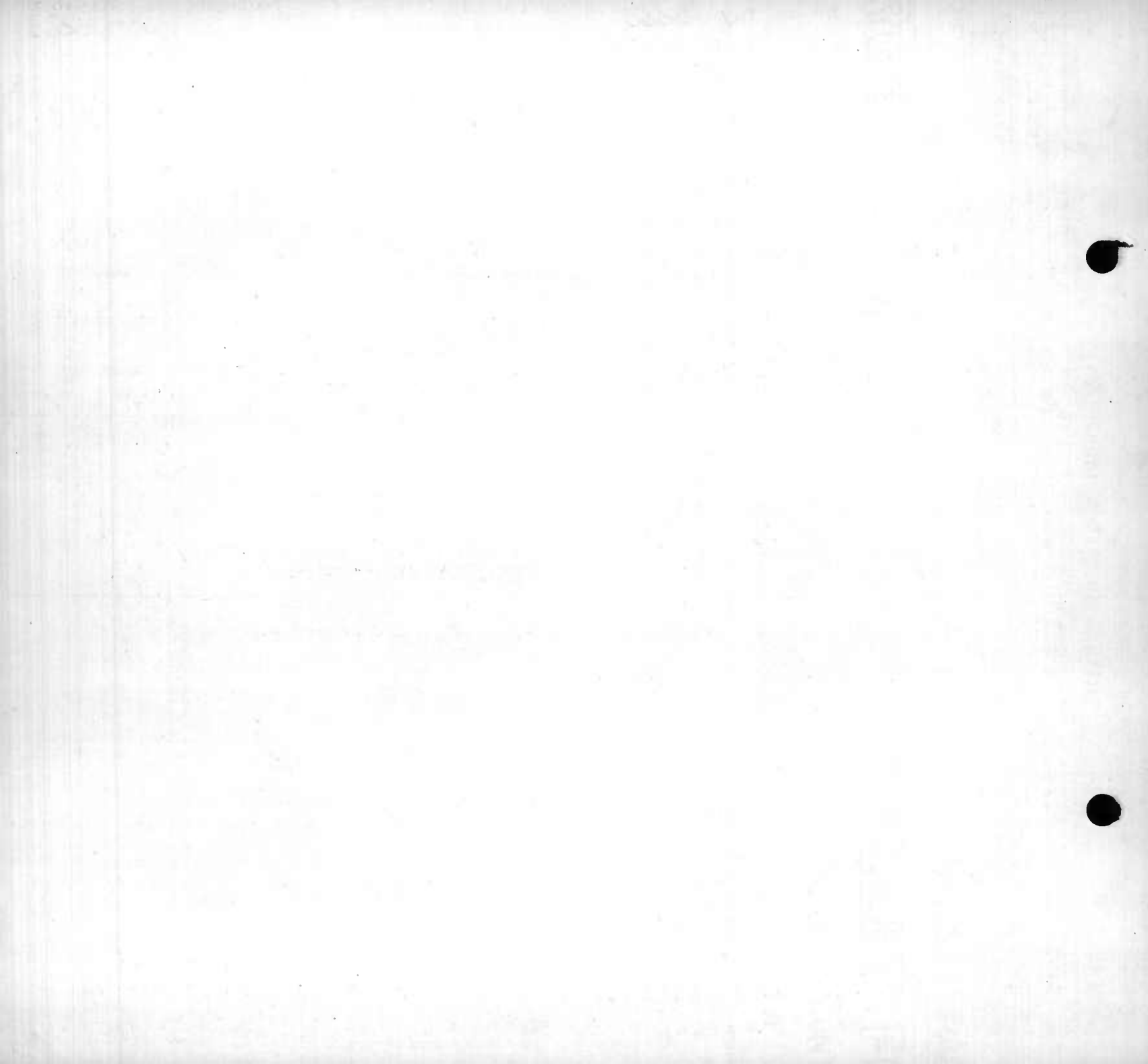
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Woolfson Albert</i>		2. DATE AND HOUR OF DEATH <i>8-10-68 6:25 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		53-00	
FULL NAME OF HOSPITAL OR INSTITUTION <i>SINAI Hospital of Baltimore Inc.</i> <i>42</i>		C. CITY OR TOWN <i>Balto</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>5947 Western Park Drive</i>		5. SEX <i>M</i>		6. RACE <i>W</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7/8/1905</i>		9. AGE (In years last birthday) <i>63</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dentist</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Solomon</i>		14. MOTHER'S MAIDEN NAME <i>Minnie</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WWII</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Wife</i>	
18. ADDRESS <i>Same</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <i>441.2 I</i>		Ruptured Abdominal Aneurysm		5 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>ASCD</i>			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>451X II</i>		Amuric Renal failure			
19A. DATE OF OPERATION <i>8-7-68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Very sick</i>		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8-7</i> 19 <i>68</i> to <i>8-10</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>8-10</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>M. Nagayoshi</i>		23B. DATE SIGNED <i>8-10-68</i>		23C. PHYSICIAN'S NAME (Type) <i>M. NAGAYOSHI</i>	
23D. ADDRESS <i>SINAI Hospital of Baltimore Inc.</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/11/68</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Hebrew Friendship Balto</i>		24D. LOCATION (City, town, or county) <i>Balto</i>		24E. DATE <i>md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 13 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Fyhrans, Junior Son, INC 9610 Resister Ave</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-8239	
1. NAME OF DECEASED (Type or Print) <b>GEORGE JACKSON</b>		2. DATE AND HOUR OF DEATH <b>8/7/68 11 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>SINA HOSPITAL</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>YES</b> E. STREET AND NUMBER <b>1019 Poplar Grove ST.</b>			
5. SEX <b>M</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/1/33</b>	9. AGE (In years last birthday) <b>34</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>US.</b>		13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>Aoia Gaslay</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Ms. Ruby Agland</b> ADDRESS <b>3714 Flourtown Rd</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>SEPTIC SHOCK</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>SEPTIC SHOCK</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>DUODENAL FISTULA DUODENOTOMY</b> (C) <b>GASTROINTESTINAL</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Intestinal Obstruction</b>			
19A. DATE OF OPERATION <b>7/30/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>FAIR</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Dr. Chloca, MD</b> INTERN DEGREE		23B. DATE SIGNED <b>8/7/68</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. Chloca</b>	
23D. ADDRESS		23E. DATE RECD BY HEALTH DEPT. <b>AUG 13 1968</b>		23F. NAME OF REGISTRAR <b>Robert E. Jenkins</b>	
23G. FUNERAL DIRECTOR <b>Earl Gilmore</b> ADDRESS <b>1827 W. North Ave.</b>		23H. NAME OF CEMETERY or CREMATORY <b>St. Lawrence Cemetery</b>		23I. LOCATION (City, town, or county) (State) <b>Nathalie, Virginia</b>	
23J. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23K. DATE <b>Aug 10 1968</b>		23L. DATE RECD BY HEALTH DEPT. <b>AUG 13 1968</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8240

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES CANNON

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

8

7

68

11:09 a. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1427 W. Fayette St.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

August 7, 1968

11:09 a. M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE

B. COUNTY

Maryland

6. SEX

7. RACE

8. MARRIED ☐ NEVER MARRIED ☒

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Male

colored

WIDOWED ☐DIVORCED ☐

Balto.

YES ☐NO ☐

9. DATE OF BIRTH

10. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

June 6, 1926

42

1427 W. Fayette St.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Princeton, N. J.

James Alexander

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Laborer

Emma Cannon

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

No

John Wilson Arlington, Virginia

19. 345.9

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Epilepsy  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

35-3.3 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

2

YES

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

August 7, 1968

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

AUG 13 1968

Robert E. Taylor, M.D.

Earl Gibson 1827 W. North Ave.

WALLLEY FORD

WALLLEY FORD

WALLLEY FORD

WALLLEY FORD

WALLLEY FORD

WALLLEY FORD

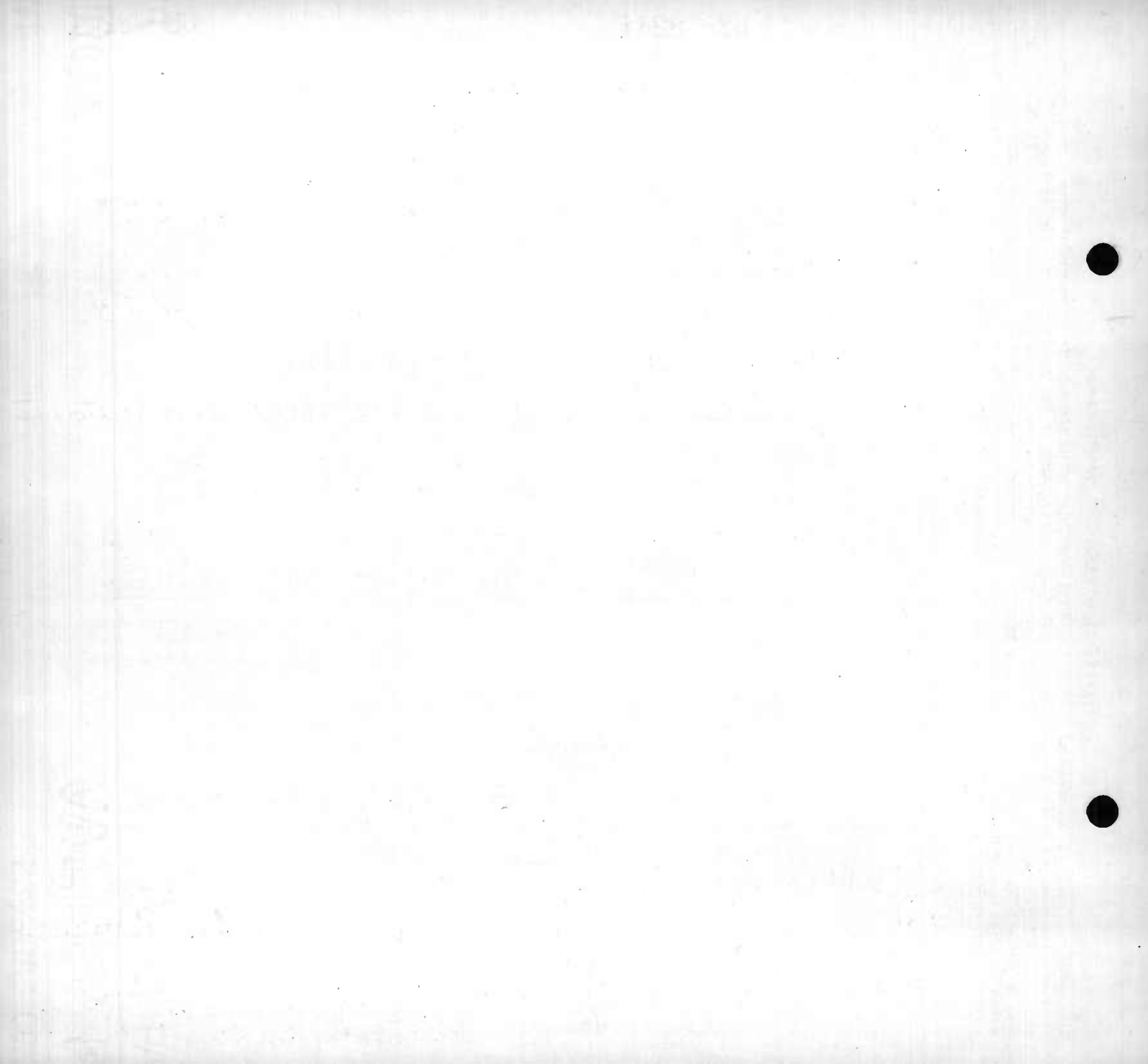
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 8241 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 8241

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARION ELLSWORTH Ensey</b>		2. DATE AND HOUR OF DEATH <b>Aug 12, 1968</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>20-03</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Bow SECOURS Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>1927 Christian St.</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 11, 1896</b>	9. AGE (In years lost birthday) <b>72</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RESIDENTIAL</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U-S-A.</b>					
13. FATHER'S NAME <b>NATHAN Ensey</b>			14. MOTHER'S MARDEN NAME <b>ANNA JONES</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES. World War I</b>		16. SOCIAL SECURITY NO. <b>218-09-8236</b>		17. INFORMANT <b>GENEVEUE Ensey</b>	
18. <b>41001</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial infarction</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ASCD</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Severe hypertension</b> (C) <b>—</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>420.1 II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-16-68</b> to <b>19 68</b> , that (I) (we) lost saw the deceased alive on <b>5-16</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Marchena MD</b>				23B. DATE SIGNED <b>8-12-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>OCTAVIO de MARCHENA MD</b>		23D. ADDRESS <b>2032 Wilkens Ave Balto 21223</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-16-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTIMORE NATIONAL BALTIMORE Md.</b>	
24D. LOCATION (City, town, or county) (State)		25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 13 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Marchena</b>		25C. FUNERAL DIRECTOR <b>Geo. L. Schwab 617 General Ave</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-8245
BIRTH NO.				
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
OTTO F. FELDT		8-11-68 12 <sup>30</sup> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
US PUBLIC HEALTH SERVICE HOSPITAL, WYMAN PARK DRIVE E 31st STREET		MARYLAND Baltimore 53-00		
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		CATONSVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER		
		924 KENT AVE		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	DEC 25, 1892	75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
LT. COL. RETIRED		USA 2nd ARMY		GERMANY
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
GUSTAV FELDT		AUGUSTINE NEUMAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
YES 1910-1947		UNK		WIFE 924 KENT AVE CATONSVILLE
18. I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		BRONCHOGENIC CARCINOMA		4 mo.
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:		
162.1 II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
6				NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) (Hour)		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from JUNE 4 1968 to AUG 11 1968, that (I) (we) lost saw the deceased alive on AUG 11 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
Francis G. Hummer MD				8-11-68
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY
Burial		8/14/68		Baltimore Nat'l Cemetery Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS
AUG 13 1968		Robert E. Jankovics		Witzke Fun. Dir., 4101 Edmondson Ave Balto., Md. 21229



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8242 CERTIFICATE OF DEATH

REG. NO.

68- 8242

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Blanche Brown

2. DATE AND HOUR OF DEATH

August 7, 1968 7:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

90

Bolton Hill Nursing &amp; Convalescent Center

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore CARROLL

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

Box 85, Oakland Rd.

5. SEX

Female

6. RACE

WHITE

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

3/15/85

9. AGE (In years  
lost birthday)

83

If Under 1 Yr.  
MonthsIf Under 24 Hrs.  
Days10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HOUSE WIFE

10B. KIND OF BUSINESS OR INDUSTRY

HOME

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William Trott

14. MOTHER'S MAIDEN NAME

Mary Conway

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown)

NO

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

218 54 0787J1

17. INFORMANT

MR GEORGE A. BROWN

ADDRESS

ABOVE

18.

410.9 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

acute coronary occlusion

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

few minutes

(B) DUE TO, OR AS A CONSEQUENCE OF:

arteriosclerosis generalized

years

(C) DUE TO, OR AS A CONSEQUENCE OF:

Bleeders - catarrhs -

years

420.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/24 1968 to 8/7 1968.  
that (I) (we) last saw the deceased alive on 8/7 1968 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Allan H. Macht

DEGREE

Attending  
Phys. ☒Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

8/7/68

23C. PHYSICIAN'S  
NAME (Type)

ALLAN H. MACHT MD

23D. ADDRESS

2 E. READ ST BALTIMORE

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8-9-68

24C. NAME OF CEMETERY or CREMATORY

New Oakland

24D. LOCATION

(City, town, or county)

(State)

Hykesville, Carroll, Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 13 1968

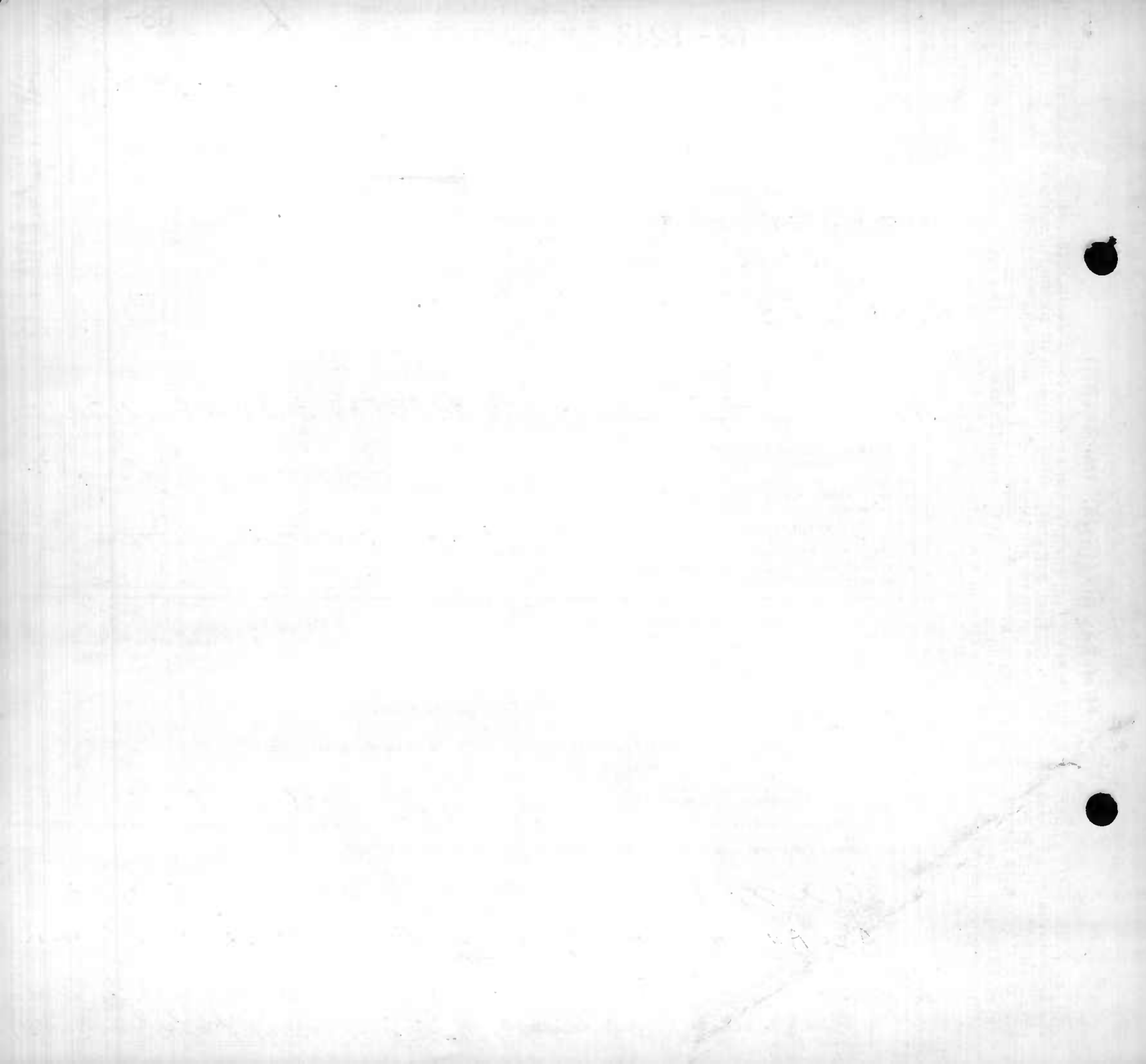
25B. NAME OF REGISTRAR

Robert E. Jenkins

25C. FUNERAL DIRECTOR

Arthur H. Haight Hykesville, Md.

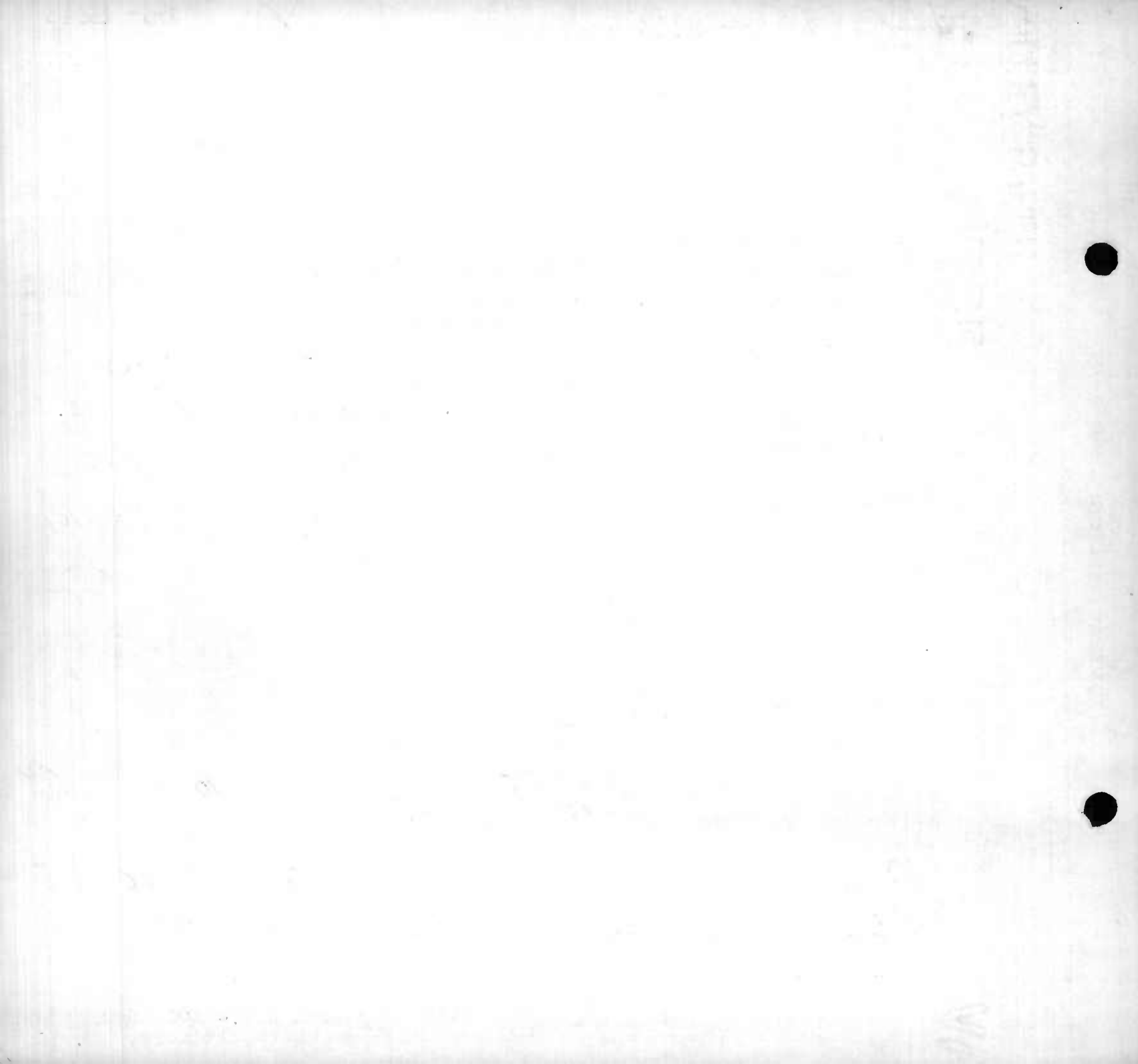
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">68- 8243</span>	
BIRTH NO. <span style="font-size: 2em;">2-535</span>		68- 8243		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>MR. FREDERICK JENTNER</u>			8-10-68 12 <sup>45</sup> P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>34 Bon Secours Hospital</u>			A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO.</u>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>		
			D. STREET ADDRESS (If rural, give location) <u>21228 6216 FREDERICK AVE</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>3-5-87</u>	9. AGE (In years lost birthday) <u>81</u>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer (retired)</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Balto. News-Post</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>JOHN M. JENTNER</u>			14. MOTHER'S MAIDEN NAME <u>SCHMELZ</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mrs. Grace Megna, 6216 Frederick Rd.</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>410.9 I MYOCARDIAL INFARCTION</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic Heart Disease</u>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u> <u>YEARS</u>
MEDICAL CERTIFICATION					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>420.1 II</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8-9-68</u> to <u>8-10-68</u> , that (I) (we) last saw the deceased alive on <u>8-10-68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Agustin del Campo</u> M.D.				23B. DATE SIGNED <u>8-10-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>AGUSTIN del CAMPO</u> M.D.				23D. ADDRESS <u>Bon Secours BALTO, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial-Mausoleum</u>		24B. DATE <u>8/14/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park Mausoleum</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 15 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taniguchi</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Witzke Funeral Dir.-4101 Edmondson Baltimore, Md. 21229</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 8244
BIRTH NO. <i>Washington D.C.</i>			68- 8244		
1. NAME OF DECEASED (Type or Print) <b>TUSSING, GEORGE FREDERICK</b>			2. DATE AND HOUR OF DEATH <b>AUGUST 12, 1968 12:43A. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>ST AGNES HOSPITAL</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>WILKENS &amp; CATON AVENUE</b> <b>BALTIMORE, MARYLAND 21229</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>21227 Baltimore 53-00</b>		
5. SEX <b>MALE</b> 6. RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>01/14/68</b> 9. AGE (In years last birthday) <b>6 29</b> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		
13. FATHER'S NAME <b>GEORGE F. TUSSING</b>			14. MOTHER'S MAIDEN NAME <b>(BEVERLEY) BETTIE</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>RECORDS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>			ADDRESS		
18. <b>486X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) Pathological dx no back yet -</b> <b>(C)</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. <b>493X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>X</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>AUGUST 1, 1968</b> to <b>AUGUST 12, 1968</b> , that (X) (we) last saw the deceased alive on <b>AUGUST 12, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Marie G. Giron</i> M.D. DEGREE			23B. DATE SIGNED <b>8-12-68</b>		
23C. PHYSICIAN'S NAME (Type) <b>MARIE GIRON</b> DEGREE			23D. ADDRESS <b>BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/13/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Johns Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Ellicott City, Howard Co., Maryland</b>		24E. (State) <b>Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 13 1968</b>		25B. NAME OF REGISTRAR <i>Robert E. Giron</i>		25C. FUNERAL DIRECTOR <b>Witzke Fun. Dir., 4101 Edmondson Ave Baltimore, Md.</b>	

21912247 7 555 1

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-8246</b>
BIRTH NO. <b>D-640</b>		<b>68-8246 CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>DAIRELL, Harriet</b>		2. DATE AND HOUR OF DEATH <b>8-7-68 5:24 p. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>The Johns Hopkins Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>9-09</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>33</b>		C. CITY OR TOWN <b>BALD.</b>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>1319 N. Eden ST</b>		
5. SEX <b>Female</b>	6. RACE <b>Negroid</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-19-36</b>	9. AGE (In years last birthday) <b>32</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>N. C.</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>?</b>		
14. MOTHER'S MAIDEN NAME <b>?</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Joseph Dairell</b>		
18. <b>394.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Probable Arrhythmia Stern-Edwards valve - Mitral Valve</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>PHD - Mitral - clusuff.</b>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>410X II Hyperventilation</b>				
19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>5:24 PM 8/7 1968</b> to <b>1968</b> , that (I) (we) last saw the deceased alive on <b>4:00 PM 8/7 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Frank C. Arnett</b>			23B. DATE SIGNED <b>8/8/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Frank C. Arnett, M.D.</b>			23D. ADDRESS <b>The Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>8/13/68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary</b>	24D. LOCATION (City, town, or county) (State) <b>A. A. County, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>8-15-68</b>	25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>	25C. FUNERAL DIRECTOR <b>Joseph D. Locks</b>		
ADDRESS <b>1304 N. Central Ave</b>				

Probable Original  
from - Column  
value - Metal Value  
GHD - Metal - Group  
Hypomethane

From 41  
GHD 8/1 28

Frank C. Smith

MEC 68-8247

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8247 CERTIFICATE OF DEATH

REG. NO. 68- 8247

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>COX, AMELIA MADELINE</b>		2. DATE AND HOUR OF DEATH <b>AUGUST 9, 1968</b>   <b>5:00 P.</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND 21061</b> B. COUNTY <b>9.4.C. 52-00</b>		C. CITY OR TOWN <b>GLENBURNIE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>40 ST. AGNES HOSPITAL WILKENS &amp; CATON AVES. BALTIMORE, MD. 21229</b>		D. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		E. STREET AND NUMBER <b>RT 2, BOX 64 SHORELAND</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>08-21-16</b>	9. AGE (In years lost birthday) <b>51</b>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>MISSOURI</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JOSEPH Mesterhazy</b>		14. MOTHER'S MAIDEN NAME <b>KATHLEEN (HORVOTH)</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>492-07-1588</b>		17. INFORMANT <b>BALTO., MD. 21229 ST. AGNES RECORDS-CATON &amp; WILKENS AVES</b>	
18. <b>199.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>HEMORRHAGIC SHOCK</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>BLEEDING LARGE DUODENAL ULCER</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>CARCINOMATOSIS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. <b>199.2 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>AUGUST 7 1968</b> to <b>AUGUST 9 1968</b> , that (X) (we) last saw the deceased alive on <b>AUGUST 9 1968</b> and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M. Cabiling</b>				23B. DATE SIGNED <b>8-10-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARINO CABILING M.D.</b>				23D. ADDRESS <b>CATON &amp; WILKENS AVES. -BALTO 21229</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>13 Aug. 68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland 21225</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. ...</b>		25C. FUNERAL DIRECTOR <b>Kirkley Funeral Home, Glen Burnie, Md.</b>	

13 Aug 68  
Cedar Hill Cemetery  
Baltimore, Maryland  
Burial  
Lillian F. [unclear] [unclear]

100-11-128

Interment

Local

Native

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8248

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 8248

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LANDORA WASHINGTON

2. DATE AND HOUR OF DEATH

8/6/68 at 12<sup>05</sup> AM.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

1331 Woodmont St. 3016 Belmont Ave.

5. SEX

Female

6. RACE

Negroid

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

3-31-04

9. AGE (In years  
last birthday)

64

If Under 1 Yr.  
Months: Days:If Under 24 Hrs.  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

Pvt. Family

11. BIRTHPLACE (State or foreign country)

King Williams Co. Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Solomon

Baylor

14. MOTHER'S MAIDEN NAME

Julia Berkley

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Madeline Deshields

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH412.41  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoporosis, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

Respiratory arrest

(B) Cerebral vascular accident  
DUE TO, OR AS A CONSEQUENCE OF:

(C) diffuse generalized ASCVD ± ↑B.P.

MEDICAL CERTIFICATION

422.1 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 31 1968 to Aug 5 1968,  
that (I) (we) last saw the deceased alive on Aug 5 1968 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

E. D. Hank Jr. M.D.

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

Intern 8/5/68

23C. PHYSICIAN'S  
NAME (Type)

Edward D. Hank Jr. M.D.

DEGREE

23D. ADDRESS

1519 E. Monument St., Baltimore, Md. 21205

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8/10/68

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

24D. LOCATION

Baltimore, Maryland

(City, town, or county)

(State)

25A. DATE RECEIVED BY HEALTH DEPT.

AUG 13 1968

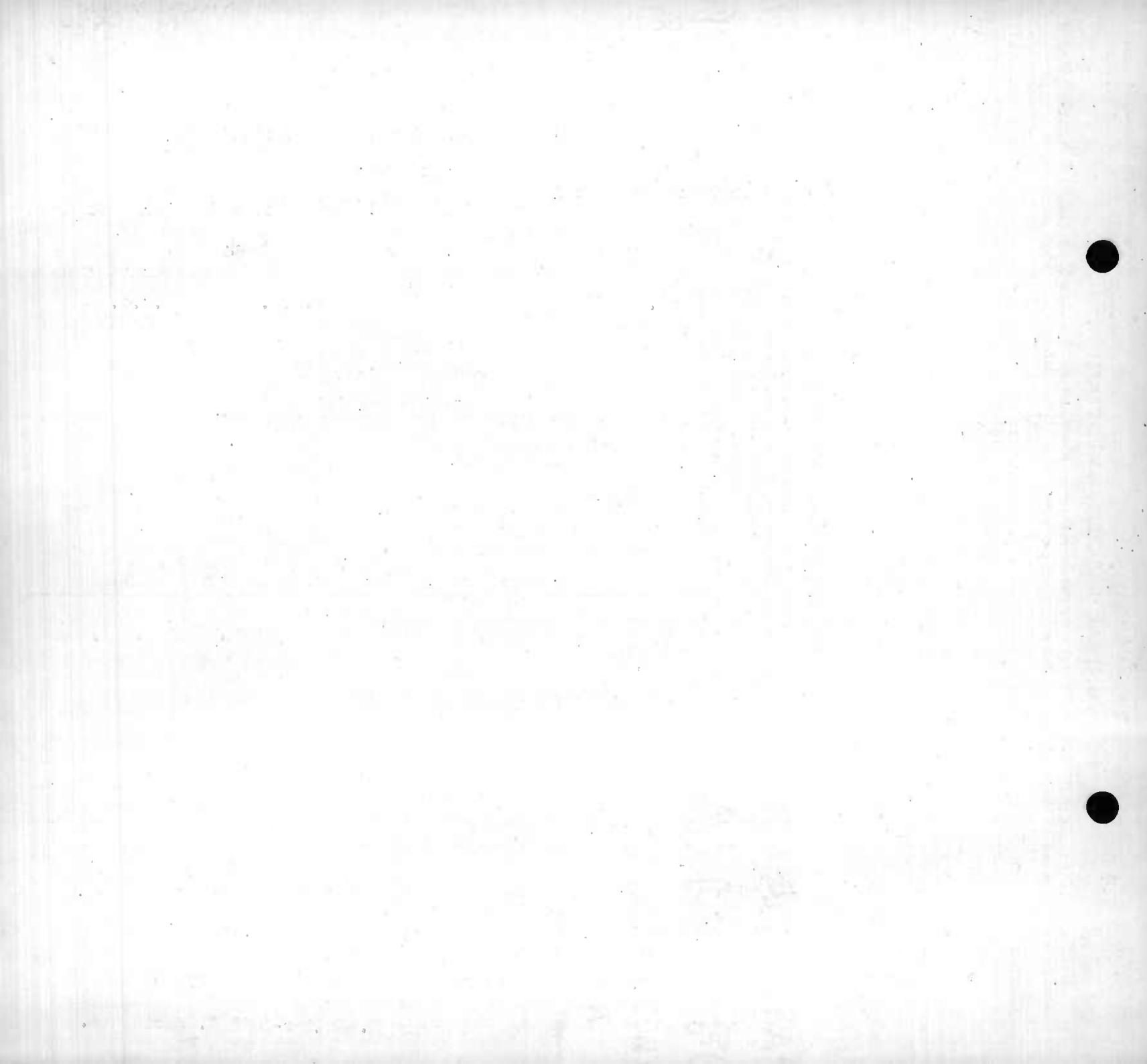
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Herbert E. Nutter-3035 W. North Ave.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8249 BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 8249

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JONES, MRS. CLEMENTINE</b>		2. DATE AND HOUR OF DEATH <b>8-8-68 1.30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution, resident, or before admission) A. STATE <b>Maryland</b> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Church Home and Hospital 100 N. Broadway, Baltimore, Maryland 21231</b>				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>212 N. Spring Court. 31 zone</b>					
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 29, 1898</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Pvt. Family</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>?</b>		
14. MOTHER'S MAIDEN NAME <b>?</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <b>212-12-2738</b>			17. INFORMANT <b>Phila Pa. Bertlee Perkins-267 E. Sharpneck Street</b>		
18. <b>174 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardio-Respiratory Failure</b> (B) <b>Cachexia due to Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Breast</b> (C) <b>Carcinoma Breast - C. Axillary metastasis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Few minutes</b>					
19. <b>170 X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>NIL</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NIL</b>		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7.31.66</b> to <b>8.8.68</b> , that (I) (we) last saw the deceased alive on <b>8.8.68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>P. K. BOSE</b> M.D. DEGREE				23B. DATE SIGNED <b>8.8.68</b>	
23C. PHYSICIAN'S NAME (Type) <b>P. K. BOSE</b> M.D. DEGREE				23D. ADDRESS <b>CHURCH HOME AND HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/13/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION <b>Baltimore Co. Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Herbert E. Nutter-3035 W. North Ave.</b>	

27

31

28

✓

✓

Cardinal

Cardinal

WIL

WIL

WIL

WIL

WIL

WIL

1  
M-343

68- 8250 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8250

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

LAWRENCE Harry MIDDLETON

2. DATE  
OF  
DEATHKnown ☐ Estimated ☒

Month

Day

Year

Hour

August 3, 1968

UNK

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

2410 Madison Avenue

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

August 5, 1968

2:50 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

Oct. 20, 1906

10. AGE (In years  
last birth)

61

# Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

2410 Madison Avenue

11. BIRTHPLACE (State or foreign country)

Paris

Illinois

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frederick Middleton

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Instructor

14B. KIND OF BUSINESS OR INDUSTRY

Morgan College

15. MOTHER'S MAIDEN NAME

Nina Brown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

327-18-8778

18. INFORMANT

Paul E. Middleton-54 Colgate Ave. Dayton Ohio

ADDRESS

Dayton Ohio

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/6/68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8/9/68

24C. NAME of CEMETERY or CREMATORY

Edgar County Cemetery

24D. LOCATION (City, town, or county)

Paris, Illinois

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 13 1968

25B. NAME OF REGISTRAR

Robert E. Farley

25C. FUNERAL DIRECTOR

Herbert E. Nutter-3035 W. North Ave.

ADDRESS

Dr. S. S. - 20

Wm. S. S. S.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 8251  
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOYCE MARIE DOWERY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>August 6, 1968 1:00 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1214 Braddish Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 6, 1968 1:00 A.M.</b>	
6. SEX <b>female</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>1/17/51</b>		10. AGE (In years last birthday) <b>17</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>NONE</b>	
18. INFORMANT <b>Mrs Vivian Jackson 2710 Ellicott Drive</b>		ADDRESS <b>Baltimore</b>	
19. <b>135510</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hepatoma</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) <b>135510</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>8/6/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/9/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Abutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore CO. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>	
25C. FUNERAL DIRECTOR <b>Herbert E. Nutter</b>		ADDRESS <b>3035 W. North Ave.</b>	



FUNERAL DIRECTOR: IMPORTANT

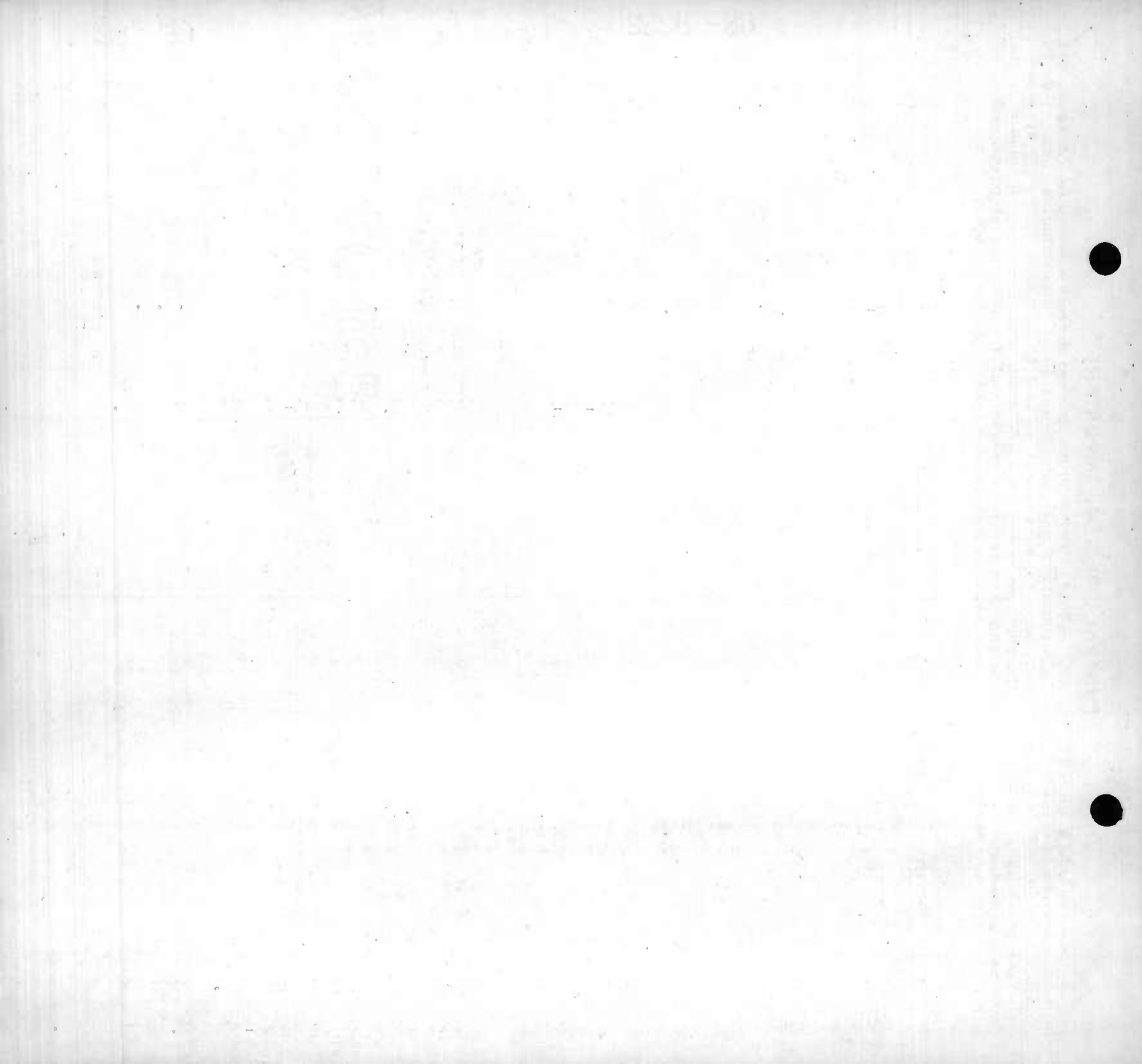
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8252

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68-15562  
68-8252

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>RIDEOUT WILLIAM T., JR.</u>		2. DATE AND HOUR OF DEATH <u>8/8/68</u> <u>11:20 AM</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>16-07</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>DUKELAND NURSING HOME</u> 1501 DUKE LAND STREET		E. STREET AND NUMBER <u>1501 DUKE LAND STREET</u>			
5. SEX <u>M</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/27/75</u>	9. AGE (In years last birthday) <u>93 YRS.</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardner-Chauffeur</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Pvt. Family</u>		11. BIRTHPLACE (State or foreign country) <u>Talbot Co. Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Asbury Rideout</u>		14. MOTHER'S MAIDEN NAME <u>Adelaid Wells</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-26-9025</u>		17. INFORMANT <u>William T. Rideout-210 Winters Ave.</u>	
18. <u>733.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slotting the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral Thrombosis</u> (B) <u>Atherosclerotic Vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>unknown</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>332X II</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <u>2/6</u> <u>1967</u> to <u>8/8</u> <u>1968</u> , that (I) (we) last saw the deceased alive on <u>8/8</u> <u>1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>D. W. STEWART, M.D.</u>		23B. DATE SIGNED <u>8/8/68</u>		23C. PHYSICIAN'S NAME (Type) <u>D. W. STEWART, M.D.</u>	
23D. ADDRESS <u>3414 DUVALL AV. (21216)</u>		23E. DEGREE _____		23F. DEGREE _____	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/12/68</u>		24C. NAME of CEMETERY or CREMATORY <u>Western Star Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Baltimore Co. Maryland</u>		24E. (State) _____		24F. (State) _____	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 13 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Nutter Funeral Home-3035 W. North Ave.</u>	
25D. ADDRESS _____		25E. ADDRESS _____		25F. ADDRESS _____	



p-620

68- 8253 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 8253

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MOZELL CHAVIS PRICE</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>August 4, 1968</b> Hour <b>10:45 A.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BON SECOURS HOSPITAL (DOA)</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 4, 1968 10:45 A.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>20-02</b>	
8. MARIED <input type="checkbox"/> NEVER MARIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH <b>Sept. 14, 1906</b>		10. AGE (In years lost birthday) <b>61</b>		E. STREET AND NUMBER <b>2505 W. Fairmount Avenue</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William H. Gardner</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Pvt. Family</b>		15. MOTHER'S MAIDEN NAME <b>Eugenia Allen</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>217-22-0520</b>		18. INFORMANT ADDRESS <b>Mrs Mae Cox 2505 W. Fairmount Ave.</b>	
19. <b>41271</b> CAUSE OF DEATH <b>Arteriosclerotic Cardiovascular Disease</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
20. DATE OF OPERATION <b>2</b> 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) <b>yes</b>					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 22F. HOW DID INJURY OCCUR?					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>August 5, 1968</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/8/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>Aug 13 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Nutter</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Herbert E. Nutter-3035 W. North Ave.</b>			

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PROB. 6015

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68- 8254 CERTIFICATE OF DEATH

REG. NO. 68- 8254

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Mrs. Lillian Avery</b>		2. DATE AND HOUR OF DEATH <b>August 9, 1968</b> <b>5:55 a.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore City</b>		C. CITY OR TOWN <b>Baltimore</b> INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Jenkins Memorial Hospital</b> <b>1000 Caton Avenue</b> <b>Baltimore, Md. 21229</b>		E. STREET AND NUMBER <b>4717 Falls Road</b>			
5. SEX <b>Female</b>	6. RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 5, 1887</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland, Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Preston</b>		14. MOTHER'S MAIDEN NAME <b>Mary Carvell</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-52-8373</b>		17. INFORMANT ADDRESS <b>Jenkins Memorial Hospital 1000 Caton Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>436.9 I Cerebro Vascular Accident recent</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Generalized arteriosclerosis years</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>331X II</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-5</b> 19 <b>68</b> to <b>8-9</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8-8</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Manuel deJ Rodriguez, M.D.</b>		23B. DATE SIGNED <b>8-9-68</b>		23C. PHYSICIAN'S NAME (Type) <b>Manuel deJ Rodriguez, M.D.</b>	
23D. ADDRESS <b>Jenkins Memorial Hospital, Balto., Md. 21229</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/12/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. Maryland</b>		25A. DATE RECEIVED <b>AUG 13 1968</b>	
25B. NAME OF REGISTRAR <b>Robert E. Tutter, Jr.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Herbert E. Nutter-3035 W. North Ave.</b>			



W-300

68- 8255 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8255

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ROY J. WHITE</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>8 10 68 9:15 a M.</b>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1313 W. Baltimore St.</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 10, 1968 9:15 a M.</b>			
6. SEX <b>Male</b>				7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>1934 34</b>				10. AGE (In years last birthday) <b>34</b>		11. BIRTHPLACE (State or foreign country) <b>OAKVALE W VA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>MUREL WHITE</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABOR</b>	
15. MOTHER'S MAIDEN NAME <b>MANDY CECIL</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO -</b>		17. SOCIAL SECURITY NO. <b>233-62-6865</b>	
18. INFORMANT <b>RANDOLPH WHITE</b>				19. ADDRESS <b>1418 LIGHT STREET 7</b>		20. CAUSE OF DEATH <b>Auto accident</b>	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>322.0 II</b>				22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>322.0 II</b>			
23A. DATE OF OPERATION <b>2</b>				23B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
24A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				24B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
24C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				24D. HOW DID INJURY OCCUR?			
24E. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>22D. TIME OF INJURY (APPROX.)</b>				24F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
25. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
26. ACTUAL SIGNATURE <b>Edward F. Wilson, M.D.</b>				27. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
28. DATE <b>AUG 13 1968</b>				29. LOCATION (City, town, or county) (State) <b>GREEN MOUNT CEMETERY GREEN MOUNT &amp; OLIVER STS MD</b>			
30. DATE REC'D BY HEALTH DEPT. <b>AUG 13 1968</b>				31. NAME OF REGISTRAR <b>Robert E. Fairbanks</b>			
32. FUNERAL DIRECTOR <b>THE DIPPEL BROS INC 1800 ELOMBARD ST</b>				33. ADDRESS			

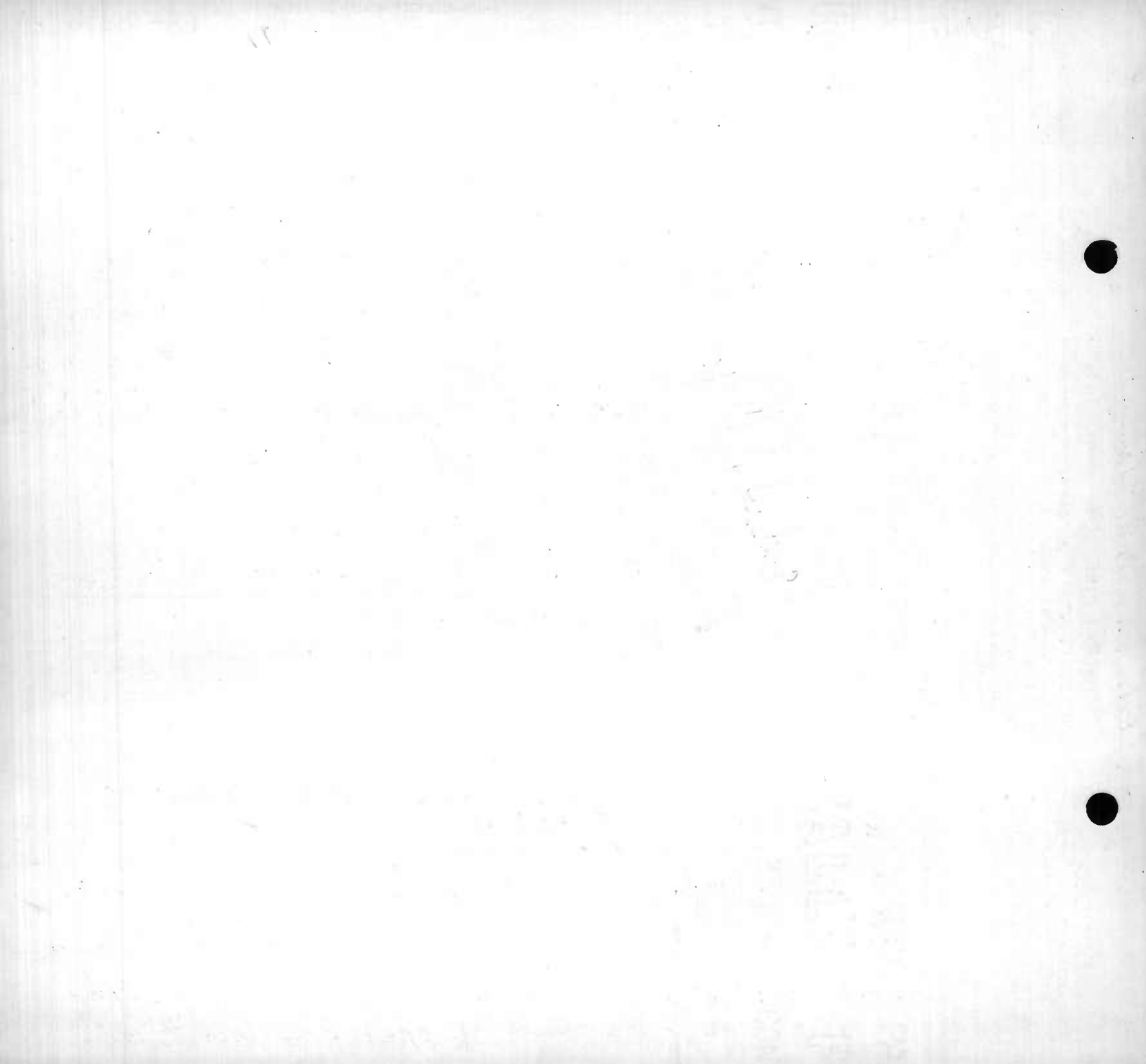


Released by Med Examin

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-8256		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-8256	
1. NAME OF DECEASED (Type or Print) <u>Lillian C. Thater</u>			2. DATE AND HOUR OF DEATH <u>Aug 10, 1968</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hosps. (DOA)</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Overlea</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>1 Madeline Avenue</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 17, 1898</u>	9. AGE (In years last birthday) <u>70</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Edward R. Thater</u>		
14. MOTHER'S MAIDEN NAME <u>Catherine Schenning</u>			15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>21590-9170</u>			17. INFORMANT <u>C. Elizabeth Thater</u> ADDRESS <u>1 Madeline Ave</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTERIOR CAUSE DISEASES OR CONDITIONS any, giving rise to the above cause, A stating the UNDERLYING CONDITION <u>422.1 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Endocarditis</u>			19. CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Atherosclerotic Cardiac</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Coronary Disease - Associated</u> (C) <u>Phenolates CVD and Subacute Bacteremia</u>		
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <u>No</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>1-3</u> 19 <u>58</u> to <u>10 Aug 68</u> 19 <u>68</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>7-13-68</u> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>we</u> ) ( <u>did</u> ) ( <u>did not</u> ) view the body after death.					
23A. SIGNATURE <u>John C. Hyle</u>			23B. DATE SIGNED <u>8-12-68</u>		
23C. PHYSICIAN'S NAME (Type) <u>John C. Hyle</u> M.D. DEGREE			23D. ADDRESS <u>7527 Belair Rd. 21236</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Aug 13, 1968</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral</u>	
24D. LOCATION <u>Baltimore, Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>AUG 13 1968</u>		24F. NAME OF REGISTRAR <u>Robert E. Tabor, MA</u>	
24G. FUNERAL DIRECTOR <u>Dippel Bros Inc.</u>		24H. ADDRESS <u>7110 Belair Rd 21206</u>		24I. DATE OF DEATH <u>Aug 10, 1968</u>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
**68- 8257 CERTIFICATE OF DEATH**

REG. NO. **68- 8257**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ANIELA M. JAWORSKI</b>		2. DATE AND HOUR OF DEATH <b>8-11-1968</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>GOULD CONVALESCARIUM</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BRADSHAW</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>BRADSHAW ROAD</b>		5. SEX <b>FEMALE</b> 6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>9-11-1896</b>		9. AGE (In years lost birthday) <b>71 YRS.</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>SKRZEK</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>John Jaworski</b> ADDRESS <b>BRADSHAW RD. BRADSHAW MD.</b>	
18. <b>4369 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Cerebral Vascular accident</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerosis.</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>331X II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/9/68</b> to <b>8/11/68</b> 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Sam Stern</b> DEGREE				23B. DATE SIGNED <b>8/12/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>SAMUEL STERN M.D.</b> DEGREE				23D. ADDRESS <b>RIDGE RD. BALTO. CO. MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-14-68</b>		24C. NAME of CEMETERY or CREMATORY <b>ST. STEPHENS CEM.</b>	
24D. LOCATION (City, town, or county) <b>BRADSHAW</b>		24E. LOCATION (City, town, or county) <b>MARYLAND</b>		24F. LOCATION (City, town, or county) <b>BRADSHAW</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>DIPPEL BROTHERS INC.</b> ADDRESS <b>7110 BELAIR RD. BALTIMORE MD.</b>	

4/15/94

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8258

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MARGUERITE HARVEY</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 11 68 3:52 a. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 5619 Mayview Ave.</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 11 1968 3:52 a. M.</b>			
6. SEX <b>Female</b>				7. RACE <b>White</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Jan. 15. 1910</b>				10. AGE (In years last birthday) <b>58</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Florent Bowers</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Wire Solderer</b>	
15. MOTHER'S MAIDEN NAME <b>Martha Register</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>214-07-2587</b>	
18. INFORMANT <b>Mr. Louis W. Harvey (Husband)</b>				19. ADDRESS <b>5619 Mayview Ave. Baltimore Md. 21206</b>		20. CAUSE OF DEATH <b>Hypertensive arteriosclerotic cardiovascular disease</b>	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>412.2</b>				22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>443X II</b>			
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				24. DATE OF OPERATION			
25. CONDITION FOR WHICH OPERATION WAS PERFORMED				26. AUTOPSY? (Yes or No) <b>No</b>			
27. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
29. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) <b>0</b>				30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
31. HOW DID INJURY OCCUR?				32. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
33. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				34. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
35. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				36. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
37. ACTUAL SIGNATURE <b>Edward F. Wilson</b> EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>				38. DATE SIGNED <b>August 11, 1968</b>			
39. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				40. DATE <b>Aug. 13. 1968</b>			
41. NAME OF CEMETERY or CREMATORY <b>Maplewood Cemetery</b>				42. LOCATION (City, town, or county) (State) <b>Elkins, West Virginia</b>			
43. DATE REC'D BY HEALTH DEPT. <b>AUG 13 1968</b>				44. NAME OF REGISTRAR <b>Robert E. Jenkins</b>			
45. FUNERAL DIRECTOR <b>HENRY SANDER &amp; SONS, INC.</b>				46. ADDRESS <b>Baltimore Md.</b>			

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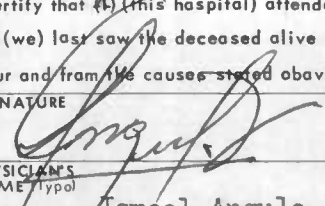
1-35-80

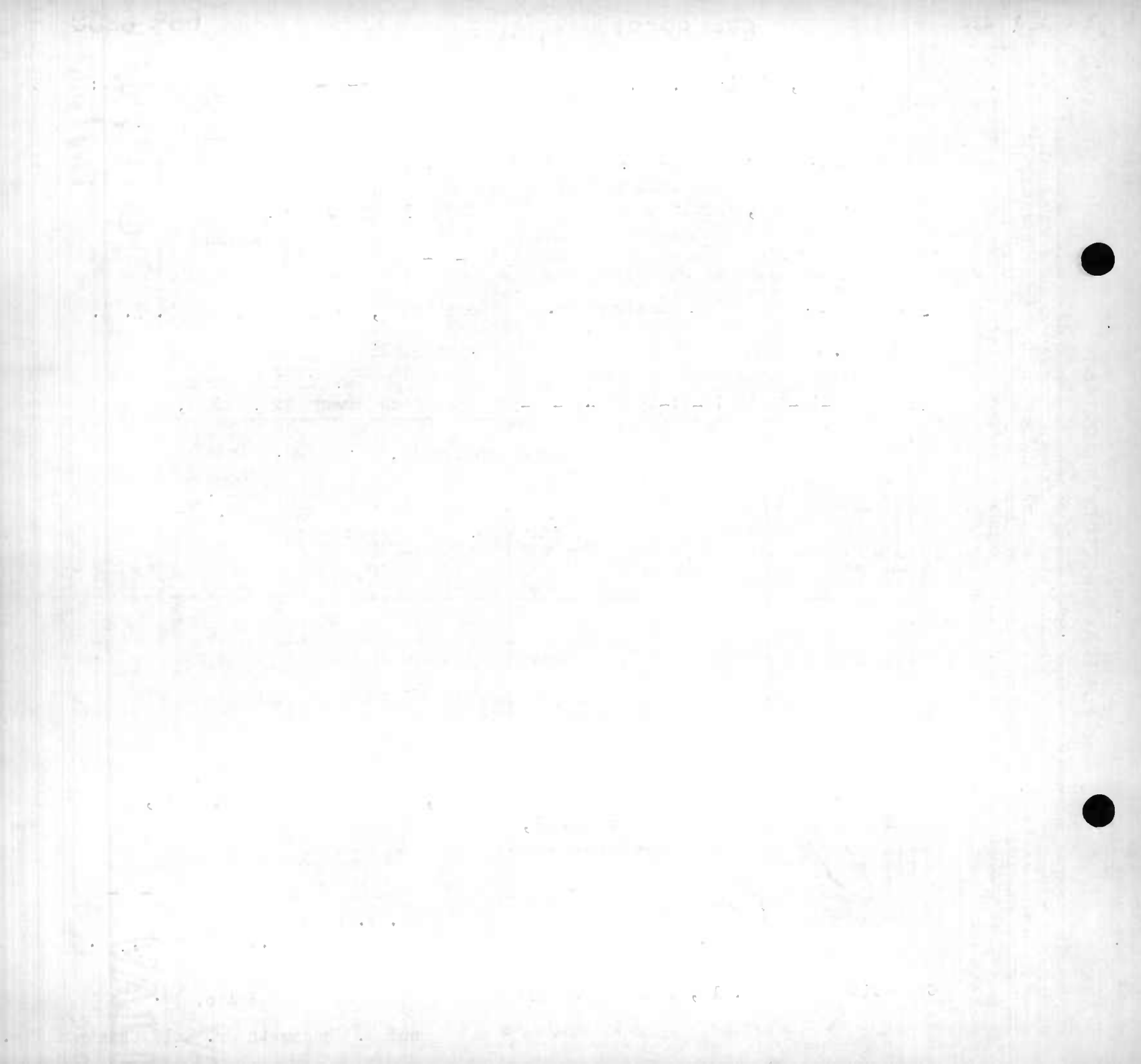
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 8259 CERTIFICATE OF DEATH

REG. NO. 68- 8259

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JACOBS, Charles P. Jr.</b>		2. DATE AND HOUR OF DEATH <b>8-10-68</b> <b>10:30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>21-02</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>		E. STREET AND NUMBER <b>1152 Cleveland Street</b>			
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>8-24-23</b>	9. AGE (In years last birthday) <b>44</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Warehouse Man</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>J. Zamanski Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Charles P. Jacobs</b>		14. MOTHER'S MAIDEN NAME <b>Anna Stulis</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 4-16-43 to 11-11-45</b>		16. SOCIAL SECURITY NO. <b>212-16-30-59</b>		17. INFORMANT <b>VA Hospital Records</b> <b>3900 Loch Raven Blvd, Balto, Md 21218</b>	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Bronchopneumonia, Right Lower Lobe</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Bronchogenic CA, right lung w/ metastasis to liver, pituitary gland &amp; thoracic vertebrae</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
162.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>July 28, 1968</b> to <b>August 10, 1968</b> , that (2) (we) last saw the deceased alive on <b>August 10, 1968</b> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) <del>not</del> view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED <b>8-10-68</b>		23C. PHYSICIAN'S NAME (Type) <b>Ismael Angulo</b>	
23D. ADDRESS <b>V. A. Hospital</b> <b>3900 Loch Raven Blvd., Baltimore, Md. 21218</b>		23E. DEGREE <b>MD</b>		23F. DEGREE <b>MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>Aug. 13, 1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Greenmount</b>	
24D. LOCATION <b>Balto, Md.</b>		24E. DATE RECD BY HEALTH DEPT. <b>AUG 13 1968</b>		24F. NAME OF REGISTRAR <b>Robert E. Jenkins</b>	
24G. FUNERAL DIRECTOR <b>Paul E. Chenoweth Jr.</b>		24H. ADDRESS <b>3617 Chestnut Ave.</b>		24I. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8260 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 68- 8260

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HOWARD Wilson</b>		2. DATE AND HOUR OF DEATH <b>August 12 1968 5:25 p. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>The Union Memorial Hosp.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>9</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>44 The Union Memorial Hosp.</b>			C. CITY OR TOWN <b>Baltimore</b> INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <b>1223 E. North Ave.</b>		
5. SEX <b>M</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/16/1922</b>	9. AGE (In years last birthday) <b>45</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Samuel Wilson, Sr.</b>			
14. MOTHER'S MAIDEN NAME <b>Elise Drakeley</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>Mrs. W.H.C. - 1223 E. North Ave. Tel: 8377469</b>			
18. <b>148.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Bleeding</b> (B) <b>Ca of Hypopharynx</b> (C) _____			
19. <b>147X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>Aug. 12/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Bleeding</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>no</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>no</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>no</b>	
21D. TIME OF INJURY (APPROX.) <b>no</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>no sig.</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>Aug. 12 1968</b> to <b>Aug. 12 1968</b> , that (I) (we) last saw the deceased alive on <b>5:25 p. 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>Aug. 12/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>NOUBAR H. DIDIZIAN M.D.</b>				23D. ADDRESS <b>U. 19. H.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/16/68</b>		24C. NAME of CEMETERY or CREMATORY <b>mt. zion</b>	
24D. LOCATION (City, town, or county) (State) <b>Longrun, Balto. Co. md.</b>		25A. DATE RECD. BY HEALTH DEPT. <b>AUG 13 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Schuyler</b>		25C. FUNERAL DIRECTOR <b>Wm. J. Chatman Jr. - 1701 Mt. Vernon St. Balto. Md.</b>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8261 CERTIFICATE OF DEATH

REG. NO. 68- 8261

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HAMPTON, PREZIE</b>		2. DATE AND HOUR OF DEATH <b>8/12/68 11:05 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO</b>		C. CITY OR TOWN <b>BALTO</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>BON SECOURS HOSPITAL</b> <b>34</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>1309 DRUID HILL AVE</b>	
5. SEX <b>M</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6/12/11</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>ELDER HAMPTON</b>		14. MOTHER'S MAIDEN NAME <b>ISABELLE BROWN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Dorothy Woods 103 S. Catherine St</b>	
18. <b>150X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cachexia</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CANCER OF ESOPHAGUS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>months</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) _____ (C) _____		<b>months</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>150X II</b> <b>Pneumonia</b>					
19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>July 9 1968</b> to <b>Aug 11 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 11 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. Meyer M.D.</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>Aug 12, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. Meyer</b>		23D. ADDRESS <b>Bon Secours Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8/15/68</b>	24C. NAME OF CEMETERY or CREMATORY <b>St. Luke's Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Balto MD</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 13 1968</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>	ADDRESS <b>3197 Schenck St</b>		



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8262

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ELEANOR DANCE		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> August 6, 1968		Month Day Year Hour August 6, 1968 9:30 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 2007 E. Lafayette Avenue		3. DATE PRONOUNCED DEAD August 6, 1968		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN Baltimore	
6. SEX female	7. RACE negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
9. DATE OF BIRTH 28 1885		10. AGE (in years last birthday) 84		E. STREET AND NUMBER 2007 E. Lafayette Avenue			
11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joe Kane			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Mary E. Body			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 217-09-657		18. INFORMANT Myrtle B Chaffin		ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 4-22-1		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Werner U Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/6/68	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug 10 1968		24C. NAME of CEMETERY or CREMATORY Carver Memorial Park		24D. LOCATION (City, town or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 13 1968		25B. NAME OF REGISTRAR Robert E. Spitz		25C. FUNERAL DIRECTOR Robert E. Williams		ADDRESS 1701 N	

Handwritten signature or initials, possibly "J. E. Smith".

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8263

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>HERBERT C. MCCOY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>August 4, 1968</b> Hour <b>3:00 AM</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>1009 S. Sharp Street (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 4, 1968 4:25 AM</b>	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
9. DATE OF BIRTH <b>Mar 8, 1903</b>		10. AGE (In years last birthday) <b>65</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>FITZHUGH MCCOY</b>		14. MOTHER'S MAIDEN NAME <b>MAGGIE JOHNSON</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Lung</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION		21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>8/4/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-7-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>MOUNT AUBURN BACTO. Md.</b>		24D. LOCATION (City, town, or county) (State) <b>ST.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkany</b>	
25C. FUNERAL DIRECTOR <b>I. L. Brown &amp; Son</b>		ADDRESS <b>23 W. Mount Airy</b>	

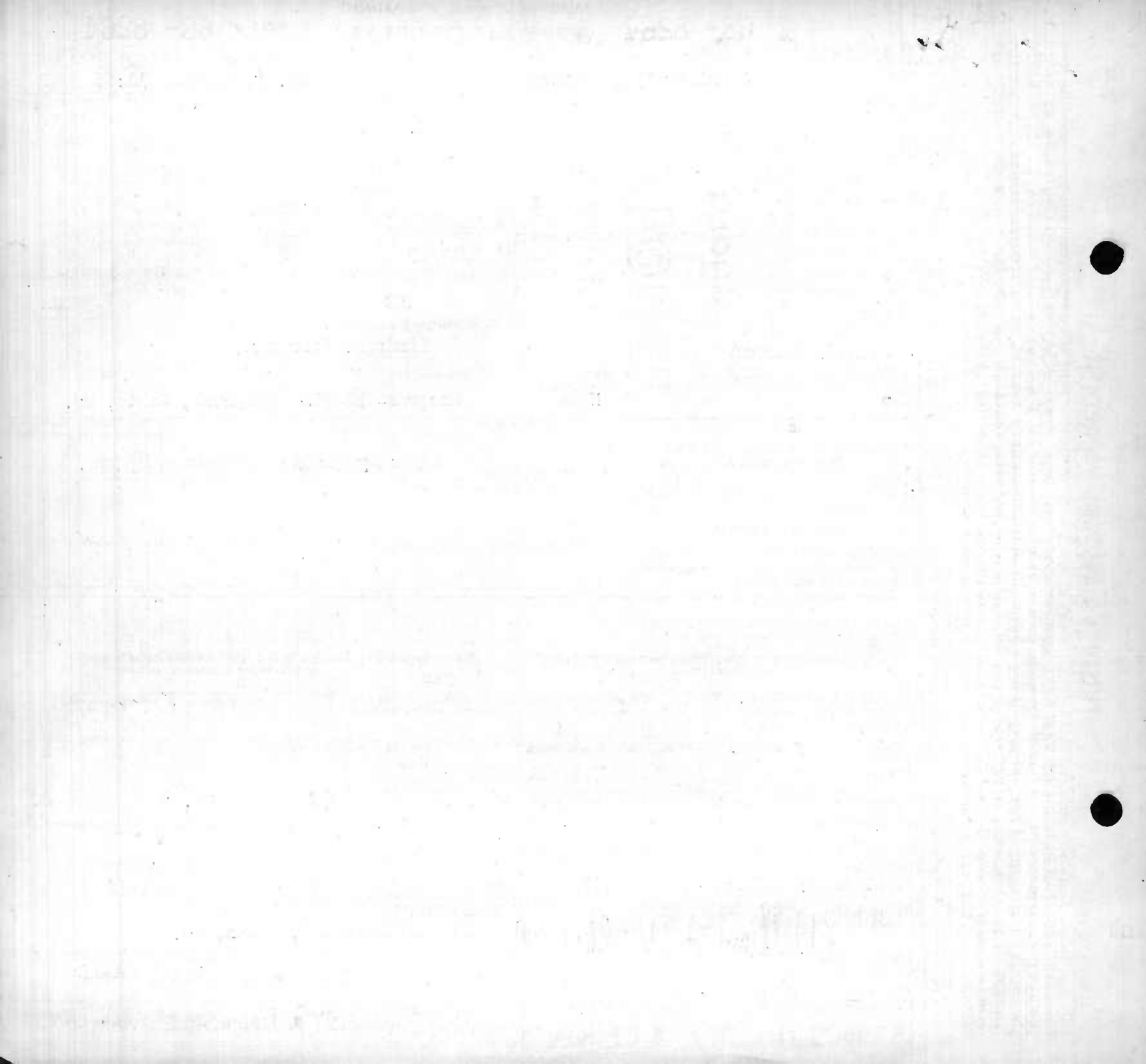
BRIAL 8-7-8 Mount Ararat, Iran. Mt.  
I. Brownish

WALL L. B. Y. B. C. R.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8264	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. <u>Washington, D.C.</u></p> <p>1. NAME OF DECEASED (Type or Print) <u>Jennifer Lynn Brennan</u></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <u>Aug. 8, 1968</u>   <u>11:55</u> P M.</p> </div> </div>					
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>US Public Health Service Hospital</u> <u>3100 Wyman Pk. Drive</u></p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Montgomery Co</u></p> <p>C. CITY OR TOWN <u>Tacoma Park</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>7303 Hilton Avenue</u></p>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/17/63</u>	9. AGE (In years last birthday) <u>4</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>DC</u>	
13. FATHER'S NAME <u>Joseph B. Brennan</u>			14. MOTHER'S MAIDEN NAME <u>Linda M. Harrison</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT ADDRESS <u>Records- US PHS Hospital, Balto, Md.</u>		
<p>18. <u>204.0 I</u> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Acute lymphatic leukemia</u></p> <p>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>			<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs.</u></p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p>		
<p>19. DATE OF OPERATION <u>204.3 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A):</p>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>yes</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>May 31</u> <u>1968</u> to <u>Aug. 8</u> <u>1968</u>, that (I) (we) last saw the deceased alive on <u>Aug. 8</u> <u>1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
23A. SIGNATURE <u>William L. Wilkie, Surgeon (R)</u>				23B. DATE SIGNED <u>8/9/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>William L. Wilkie MD</u>				23D. ADDRESS <u>US PHS Hospital, Balto, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8-10-1968</u>		24C. NAME OF CEMETERY or CREMATORY <u>WASHINGTON NATIONAL</u>	
24D. LOCATION (City, town, or county) (State) <u>SUITLAND, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 13 1968</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR ADDRESS <u>W.W. CHAMBERS CO, RIVERDALE, MARYLAND</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-500				68- 8265		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 8265	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				JOSEPH I. COHEN		AUGUST 12, 1968		12 NOON M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				MARYLAND		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
5600 PIMLICO ROAD, 2nd FLOOR						BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				5600 PIMLICO ROAD, 2nd FLOOR					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2-4-1896	72					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
AGENT			INSURANCE		COLUMBIS, SOUTH CAROLINA		U.S.A.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
JACK M. COHEN				CARIE G. GOLDSMITH					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
YES W.W. I ARMY				218-32-1830		MRS. BESSIE W. COHEN, 5600 PIMLICO RD. 2nd FL.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				2 hrs.	
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:				1 year.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Ch. Sclerosis.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				None					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from July 31 1967 to Aug 12 1968 that (I) (we) last saw the deceased alive on Aug 8 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Bernard J. Cohen				8/12/68					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
BERNARD J. COHEN				3501 ST. PAUL STREET					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
CREMATION		8-13-68		LOUDON PARK CREMATORY		BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
AUG 13 1968		Robert E. Johnson		SOL LEVINSON & BROS.		6010 REISTERSTOWN ROAD			

RECEIVED

RECEIVED

Handwritten notes in cursive script, possibly a signature or address.

Handwritten word, possibly "Yours".

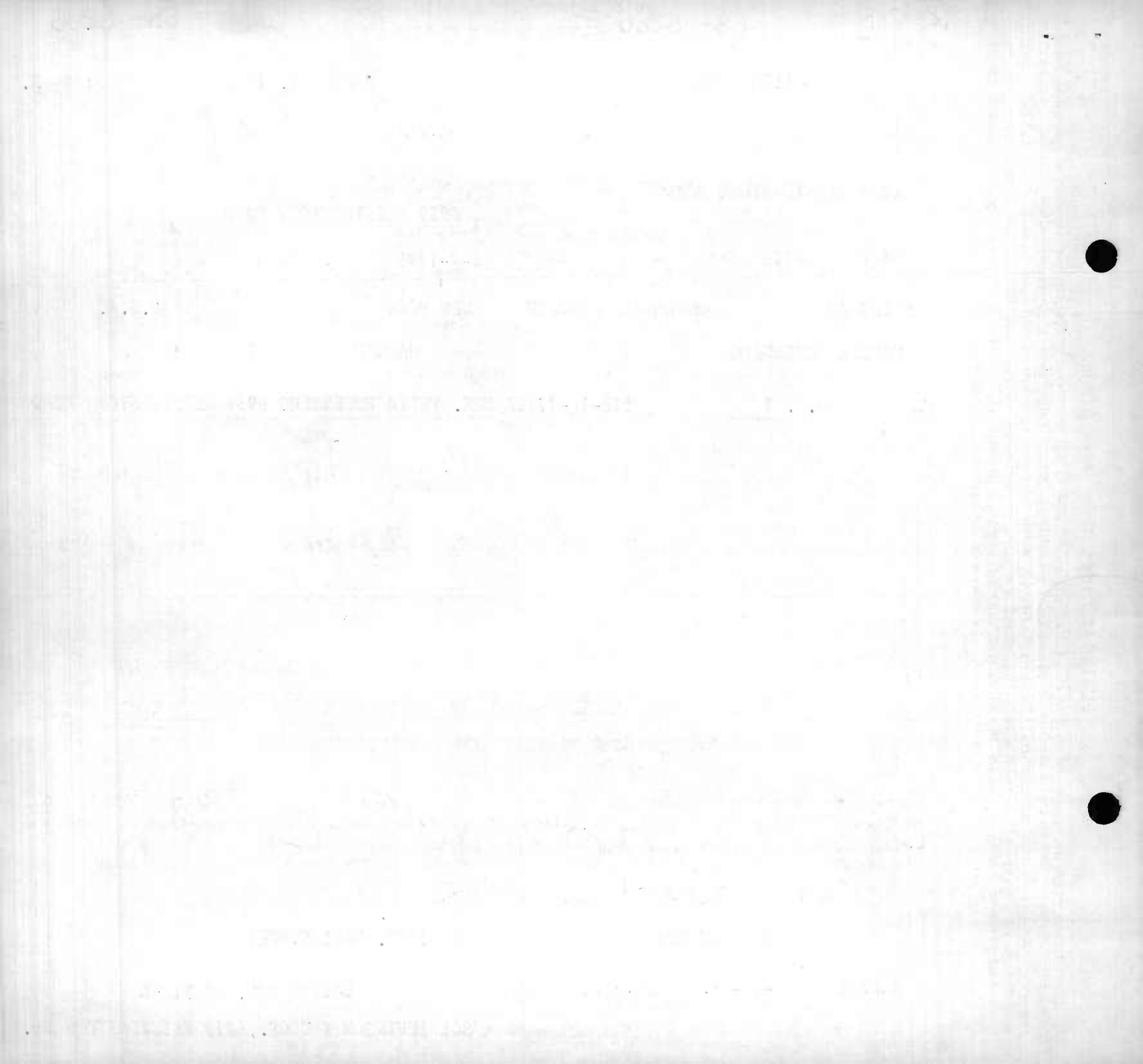
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

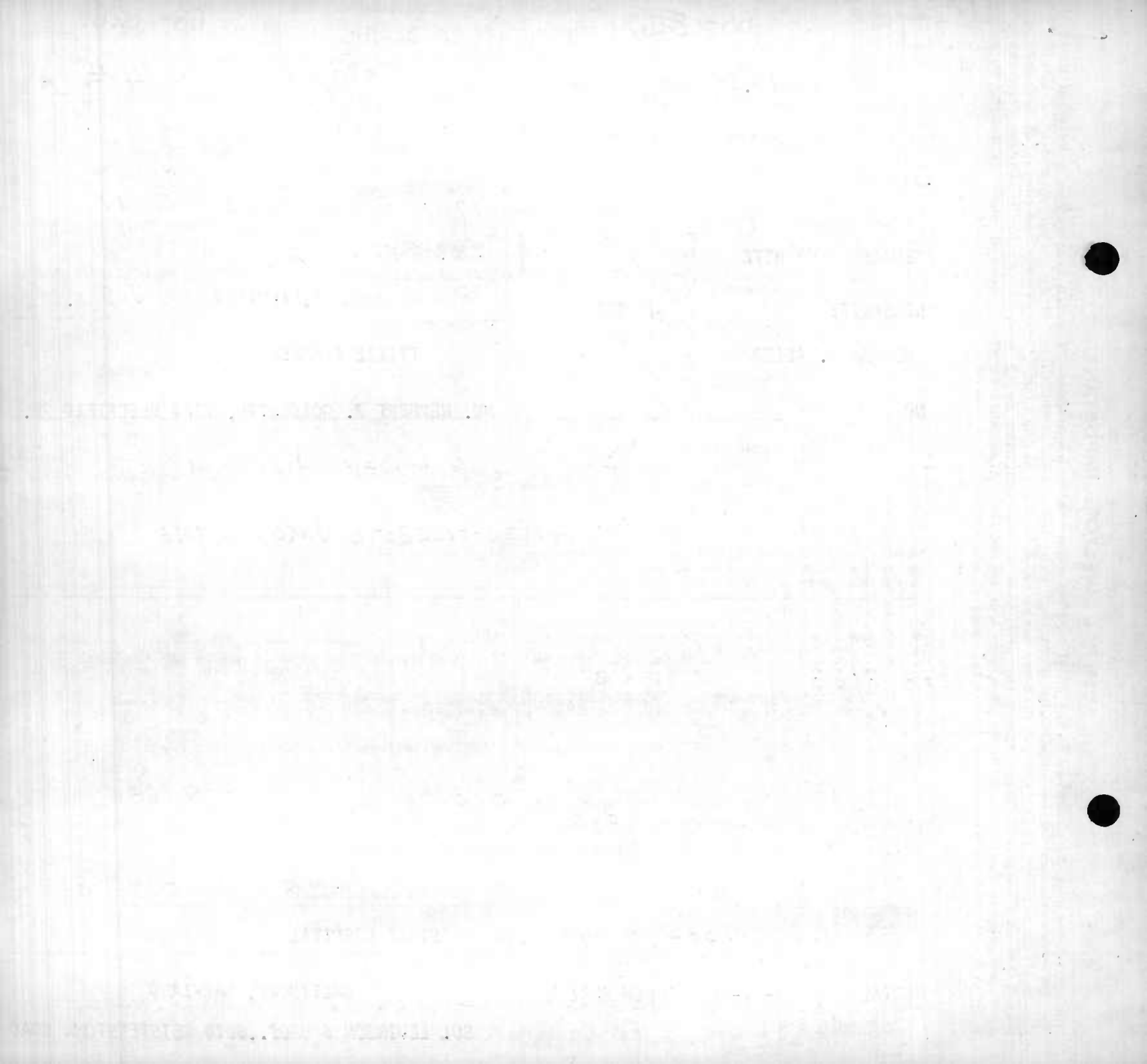
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8266	
R-251		68- 8266		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WILLIAM ROSENBERG		AUGUST 9, 1968 3:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND			
		B. COUNTY 27-20			
6939 REISTERSTOWN ROAD		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 6939 REISTERSTOWN ROAD			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-4-1895	9. AGE (In years last birthday) 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY WHOLESALE GROCERY		11. BIRTHPLACE (State or foreign country) NEW YORK	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME SAMUEL ROSENBERG			
14. MOTHER'S MAIDEN NAME HANNAH ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. I			
16. SOCIAL SECURITY NO. 216-10-1742A		17. INFORMANT ADDRESS MRS. VETTA ROSENBERG 6939 REISTERSTOWN ROAD			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE Pulmonary Insufficiency DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month	
(B) Pulmonary Emphysema DUE TO, OR AS A CONSEQUENCE OF		(C)		10 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 9 1968 to Aug 9 1968, that (I) (we) last saw the deceased alive on Aug 9 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Leon E Kassel		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) LEON KASSEL	
23D. ADDRESS 3501 ST. PAUL STREET		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE 8-11-68		24C. NAME of CEMETERY or CREMATORY SHAAREI TFILOH		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 13 1968		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN RD.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G432		68- 8267		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 8267	
1. NAME OF DECEASED (Type or Print) <b>EILEEN A. GOLD SMITH</b>				2. DATE AND HOUR OF DEATH <b>8/9/68 4 15 A M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>14-01</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL</b> <b>42</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1701 EUTAW PLACE E 17</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>W HITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>[REDACTED]</b>	9. AGE (In years lost birthday) <b>81</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HERMAN S. ADLER</b>				14. MOTHER'S MAIDEN NAME <b>TILLIE FRANKEL</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MR. HERBERT J. GOLDSMITH, 7104 DEERFIELD RD.</b>			
18. <b>44191</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <b>RUPTURED ANEURYSM</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>ARTERIOSCLEROTIC VASC. DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>43 IX II</b>							
19A. DATE OF OPERATION <b>8/8/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>FAIR</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8/8/68</b> 19 to <b>8/9/68</b> 19, that (I) (we) last saw the deceased alive on <b>8/8</b> 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>JR Chloca, MD</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>8/9/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>I. R. CHLOCA, MD</b>				23D. ADDRESS <b>SINAI HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-11-68</b>		24C. NAME of CEMETERY or CREMATORY <b>OHEB SHALOM</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			



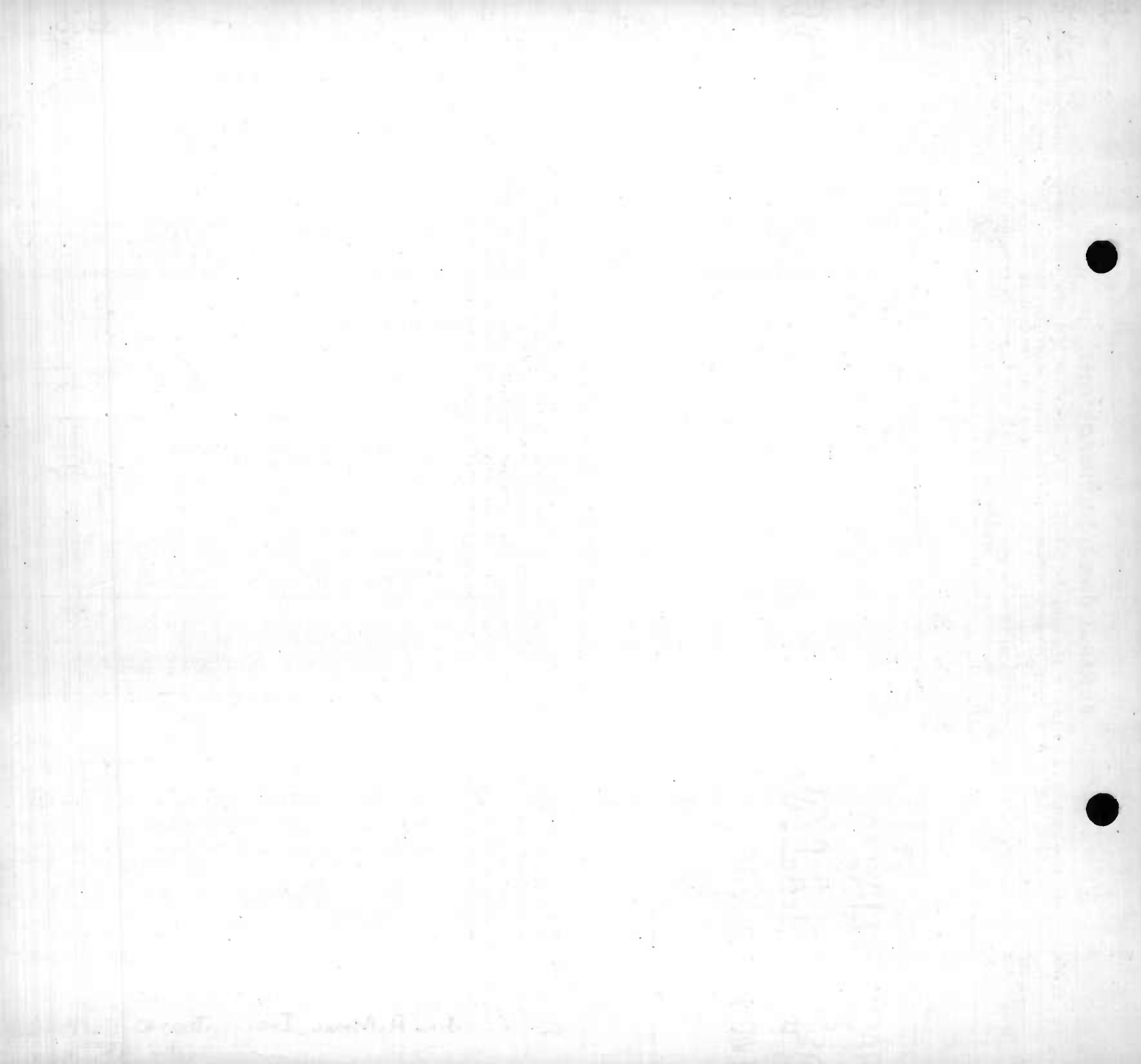
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8268 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 68- 8268

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARIE E. PITIPAV</b>		2. DATE AND HOUR OF DEATH <b>8-11-68</b> <b>8<sup>30</sup> P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSP</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>12-03</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2843 ST. PAUL STREET</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-12-1900</b>	9. AGE (In years lost birthday) <b>67</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <del>XXXXXXXXXX</del> <b>Andrew Hennessey</b>		14. MOTHER'S MAIDEN NAME <del>XXXXXXXXXX</del> <b>Anna Ritterbusch</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-32-0445</b>		17. INFORMANT ADDRESS <b>Anna Hennessey 138 N. Glover St.</b>	
18. CAUSE OF DEATH 18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>GI BLEEDING</b> 18B. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>DIFFUSE CARCINOMATOSIS</b> <b>CARCINOMA OF GALL BLADDER</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>13-5-1 II</b>					
19A. DATE OF OPERATION <b>18-10-1968</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>GI bleeding</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>8-7</b> 19 <b>68</b> to <b>8-11</b> 19 <b>68</b> , that (1) (we) last saw the deceased alive on <b>8-11</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>D.H. Brancato M.D.</b>				23B. DATE SIGNED <b>8-11-1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>D.H. BRANCATO M.D.</b>				23D. ADDRESS <b>UNION MEMORIAL HOSP.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/16/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 13 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. [unclear]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>John A. Moran, Inc. 3000 E. Baltimore city 24, Md.</b>			



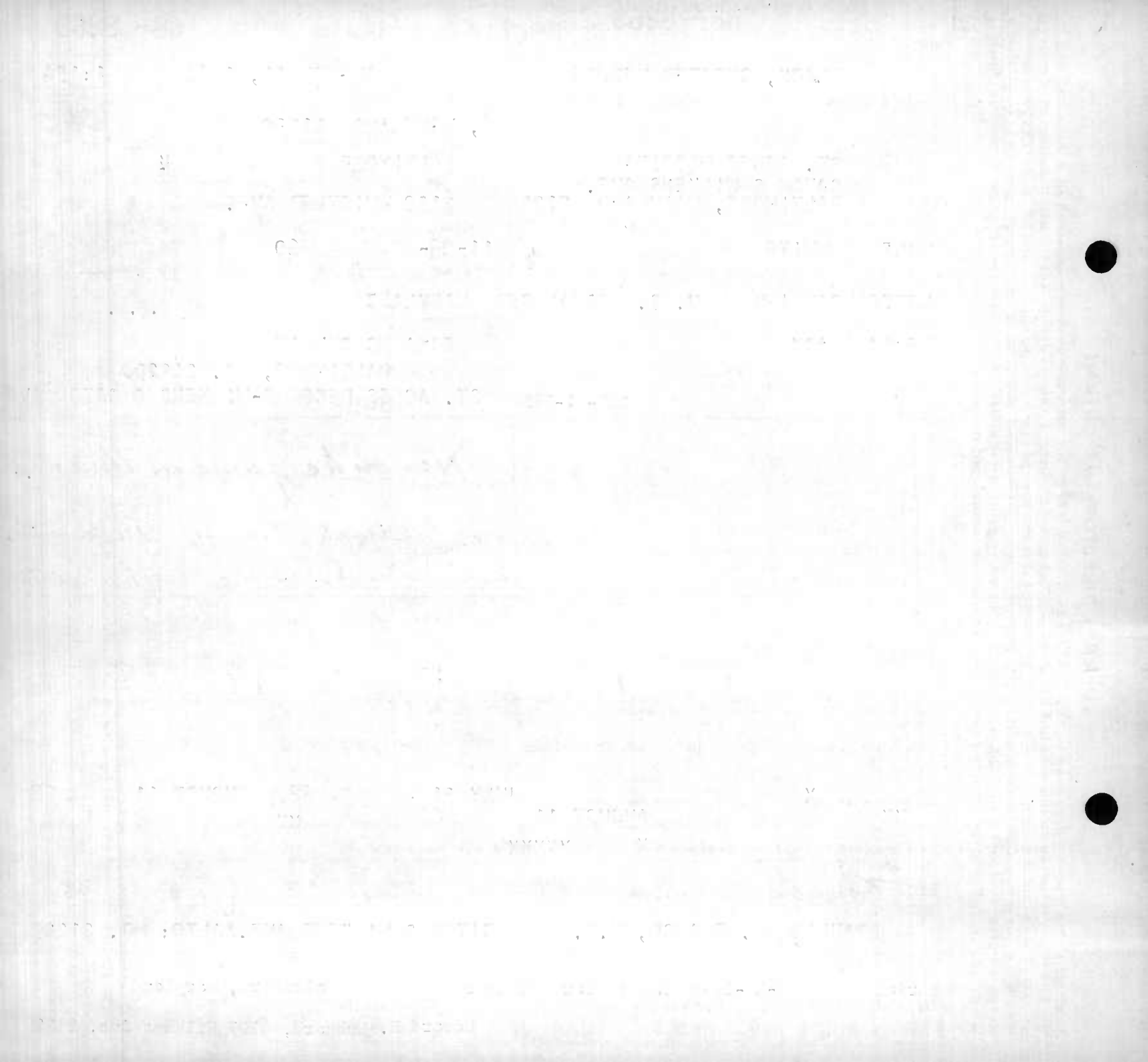
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8269

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 8269

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>PLACK, CHESTER VERNON</b>		2. DATE AND HOUR OF DEATH <b>AUGUST 11, 1968 1:15A</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>21230</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL CATON &amp; WILKENS AVE. BALTIMORE, MARYLAND 21229</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>2130 WHISTLER AVE.</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-06-07</b>	9. AGE (In years lost birthday) <b>60</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LETTER CARRIER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U. S. POSTAL SER</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>HENRY PLACK</b>		14. MOTHER'S MAIDEN NAME <b>EDNA MC CUBBIN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-42-7654</b>		17. INFORMANT <b>BALTIMORE, MD. 21228</b> <b>ST. AGNES RECORDS-WILKENS &amp; CATON AVE</b>	
18. <b>15381</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>NEUROLITIC JAUNDICE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Brain Metastatic Tumor.</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Neurolitic Jaundice</b> (B) <b>Brain Metastatic Tumor</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma Colon.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Three days</b> <b>Two months</b> <b>Three months</b>	
19. <b>15381 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>JULY 31</b> 19 <b>68</b> to <b>AUGUST 11</b> 19 <b>68</b> , that (X) (we) lost saw the deceased alive on <b>AUGUST 11</b> 19 <b>68</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE <b>Braulio O. Franco</b>		23B. DATE SIGNED <b>8-11-68</b>			
23C. PHYSICIAN'S NAME (Type) <b>BRAULIO O. FRANCO, M.D.</b>		23D. ADDRESS <b>CATON &amp; WILKENS AVE. BALTO; MD. 21229</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-14-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>	



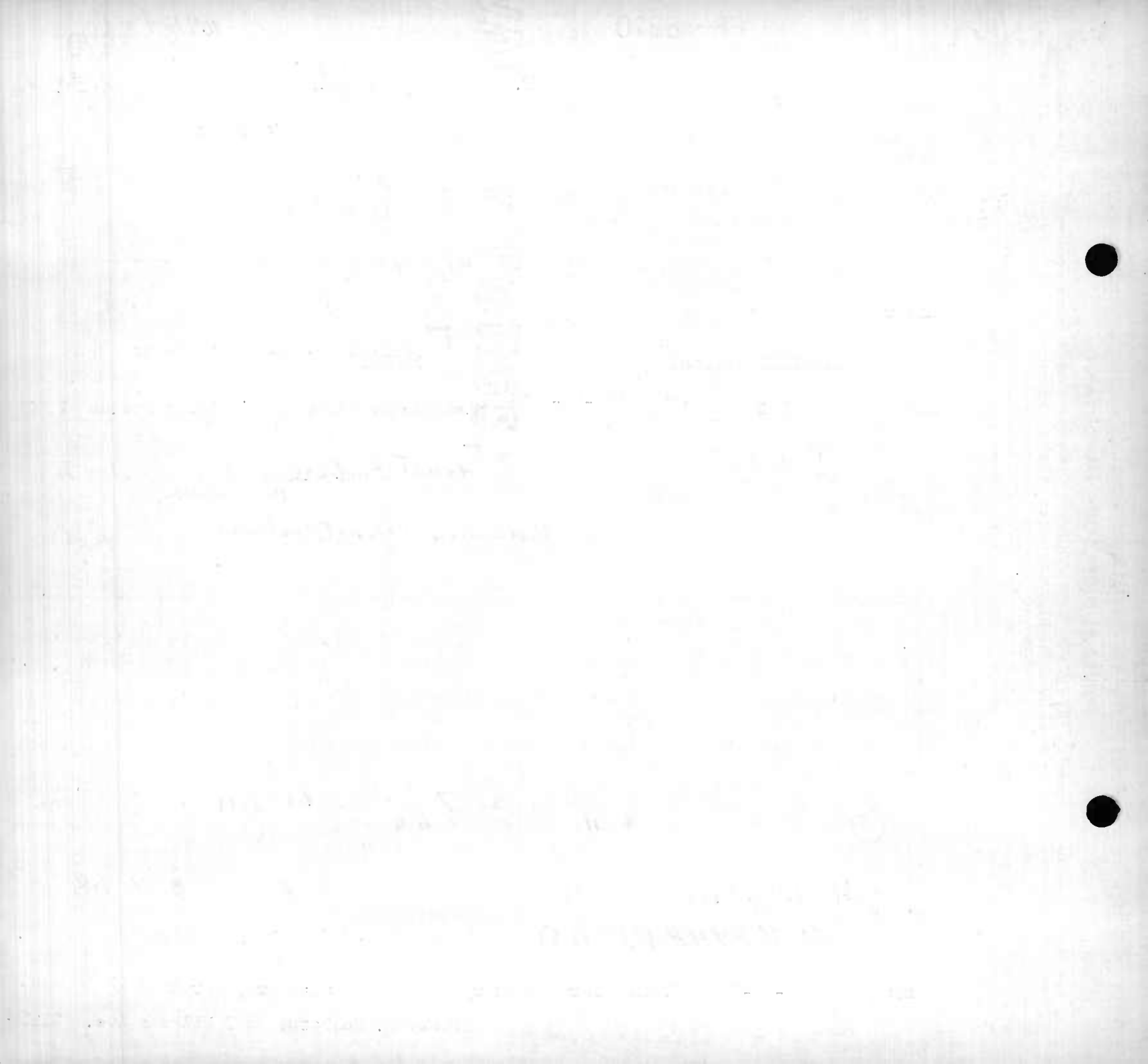
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8270 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 109164 or 68- 8270

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Michael, Mr Charles F.</i>		2. DATE AND HOUR OF DEATH <i>8/11/68 11:30 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Bon Secours Hospital 34 2025 West Fayette Street Baltimore Maryland</i>				C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>917 Leeds Ave.</i>					
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/28/88</i>	9. AGE (In years last birthday) <i>80</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>					
13. FATHER'S NAME <i>Otto F. Michael</i>			14. MOTHER'S MAIDEN NAME <i>Wilhelmina Mobus</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes W W I</i>		16. SOCIAL SECURITY NO. <i>218-36-6774</i>		17. INFORMANT ADDRESS <i>Miss Minnie Michael, 917 Leeds Avenue 21229</i>	
18. <i>593.2 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshteno, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Acute Heart Failure and Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Kidney and Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>days</i> <i>years</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>5-93X II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>8. 7</i> 19 <i>68</i> to <i>8. 11</i> 19 <i>68</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>8. 11</i> 19 <i>68</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <i>(did not)</i> view the body after death.					
23A. SIGNATURE <i>M. Keyhani M.D.</i>				23B. DATE SIGNED <i>8. 11. 68</i>	
23C. PHYSICIAN'S NAME (Type) <i>M. KEYHANI M.D.</i>				23D. ADDRESS <i>Bon Secours Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-14-1968</i>		24C. NAME of CEMETERY or CREMATORY <i>Loudon Park Cemetery</i>	
24D. LOCATION <i>Baltimore, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 13 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Faldut</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Howard H. Hubbard, 4107 Wilkens Ave. 21229</i>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8271				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 8271	
<div style="display: flex; justify-content: space-between;"> <div> <p><b>BIRTH NO.</b></p> <p>1. NAME OF DECEASED (Type or Print) <b>ESTHER M. CORKRAN</b></p> </div> <div> <p>2. DATE AND HOUR OF DEATH</p> <p><b>August 10, 1968</b></p> </div> </div>							
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><b>90 Long Green Nursing Home</b></p>				<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b></p> <p>C. CITY OR TOWN <b>Arbutus</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER <b>922 Leeds Avenue</b></p>			
<p>5. SEX</p> <p><b>Female</b></p>	<p>6. RACE</p> <p><b>White</b></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH</p> <p><b>8-20-1893</b></p>	<p>9. AGE (In years last birthday)</p> <p><b>74</b></p>	<p>If Under 1 Yr. Months: Days: Hours: Min.</p>	<p>If Under 24 Hrs. Hours: Min.</p>	<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><b>Housewife</b></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><b>Housewife</b></p>			<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country)</p> <p><b>Maryland</b></p>		<p>12. CITIZEN OF WHAT COUNTRY?</p> <p><b>U.S.A.</b></p>
<p>13. FATHER'S NAME</p> <p><b>Burley Gill</b></p>			<p>14. MOTHER'S MAIDEN NAME</p> <p><b>Elsie Ebaugh</b></p>			<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>	
<p>16. SOCIAL SECURITY NO.</p> <p><b>218-14-0458</b></p>			<p>17. INFORMANT ADDRESS</p> <p><b>Rev. Edwin G. Reter, 5024 Gwynn Oak Ave. 21207</b></p>				
<p>18. <b>440.9 I</b> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>Anterosclerosis</b></p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>							
<p>19. <b>450.0 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>							
<p>19A. DATE OF OPERATION</p> <p><b>0</b></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p> <p><input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from <b>Oct 12 1968</b> to <b>Aug 10 1968</b>, that (I) (we) last saw the deceased alive on <b>Aug 19 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (they) (did not) view the body after death.</p>							
<p>23A. SIGNATURE</p> <p><b>Dr. Wm. G. Helfrich</b></p>						<p>23B. DATE SIGNED</p> <p><b>Aug 12 - 68</b></p>	
<p>23C. PHYSICIAN'S NAME (Type)</p> <p><b>Dr. Wm. G. Helfrich</b></p>		<p>23D. ADDRESS</p> <p><b>5006 Roland Avenue, Balto., Md. 21210</b></p>					
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p><b>Burial</b></p>		<p>24B. DATE</p> <p><b>8-13-1968</b></p>	<p>24C. NAME of CEMETERY or CREMATORY</p> <p><b>Meadowridge Cemetery</b></p>		<p>24D. LOCATION (City, town, or county) (State)</p> <p><b>Howard County, Maryland</b></p>		
<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p><b>AUG 13 1968</b></p>		<p>25B. NAME OF REGISTRAR</p> <p><b>Robert E. Taylor</b></p>		<p>25C. FUNERAL DIRECTOR ADDRESS</p> <p><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b></p>			



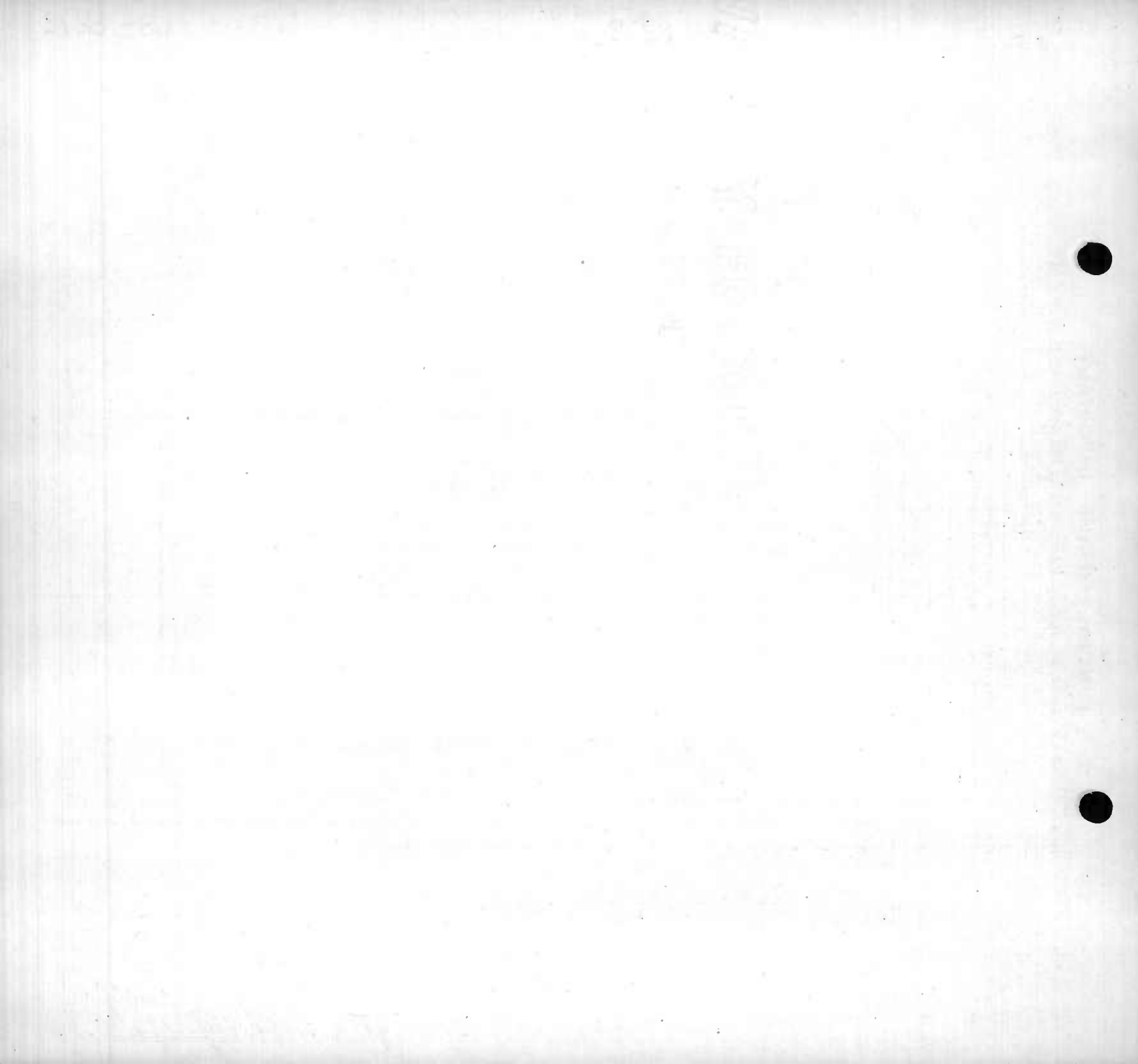
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 68- 8272 CERTIFICATE OF DEATH

REG. NO. 68- 8272

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <div style="text-align: center;">Sarah W. Clayton</div>		2. DATE AND HOUR OF DEATH <div style="text-align: center;">August 11, 1968 4:00 P.M.</div>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <div style="text-align: center;">Maryland</div> B. COUNTY <div style="text-align: center;">13-01</div>		C. CITY OR TOWN <div style="text-align: center;">Baltimore</div>	
FULL NAME OF HOSPITAL OR INSTITUTION <div style="text-align: center;">00 2409 Eutaw Place Baltimore, Maryland</div>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <div style="text-align: center;">Female</div>		6. RACE <div style="text-align: center;">Colored</div>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> SEPARATED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center;">House Wife</div>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <div style="text-align: center;">Jan 31, 1896 72</div>	
11. BIRTHPLACE (State or foreign country) <div style="text-align: center;">Virginia</div>		12. CITIZEN OF WHAT COUNTRY? <div style="text-align: center;">USA</div>		9. AGE (In years lost birthday)	
13. FATHER'S NAME <div style="text-align: center;">Armstead Williams</div>		14. MOTHER'S MAIDEN NAME <div style="text-align: center;">Lucy Griffin</div>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <div style="text-align: center;">No</div>	
16. SOCIAL SECURITY NO. <div style="text-align: center;">220-12-4490</div>		17. INFORMANT <div style="text-align: center;">Harold Williams</div>		ADDRESS <div style="text-align: center;">2303 W. Mosher Street</div>	
18. CAUSE OF DEATH <div style="text-align: center;">402 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</div>		(A) IMMEDIATE CAUSE <div style="text-align: center;">Myocardial Insufficiency</div> (B) DUE TO, OR AS A CONSEQUENCE OF: <div style="text-align: center;">Hypertension Gen Arteriosclerosis</div> (C) <div style="text-align: center;">Gen Arteriosclerosis</div>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION 19A. DATE OF OPERATION <div style="text-align: center;">443 X II</div>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <div style="text-align: center;">no</div>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <div style="text-align: center;">8/2</div> 1968 to <div style="text-align: center;">8/12</div> 1968, that (I) (we) last saw the deceased alive on <div style="text-align: center;">8/12</div> 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <div style="text-align: center;">Dr. Herman Seidel</div>		23B. DATE SIGNED <div style="text-align: center;">8/10/68</div>		23C. PHYSICIAN'S NAME (Type) <div style="text-align: center;">1</div>	
23D. ADDRESS <div style="text-align: center;">2404 Eutaw Pl</div>		23E. DEGREE		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <div style="text-align: center;">Burial</div>		24B. DATE <div style="text-align: center;">8-15-68</div>		24C. NAME OF CEMETERY or CREMATORY <div style="text-align: center;">Graston</div>	
24D. LOCATION (City, town, or county) (State) <div style="text-align: center;">Taffing Virginia</div>		24E. DATE RECEIVED BY HEALTH DEPT. <div style="text-align: center;">AUG 13 1968</div>		24F. NAME OF REGISTRAR <div style="text-align: center;">Robert E. Farkner</div>	
24G. FUNERAL DIRECTOR <div style="text-align: center;">Arlington Phillips</div>		24H. ADDRESS <div style="text-align: center;">172 W. Mount</div>		24I. ADDRESS	



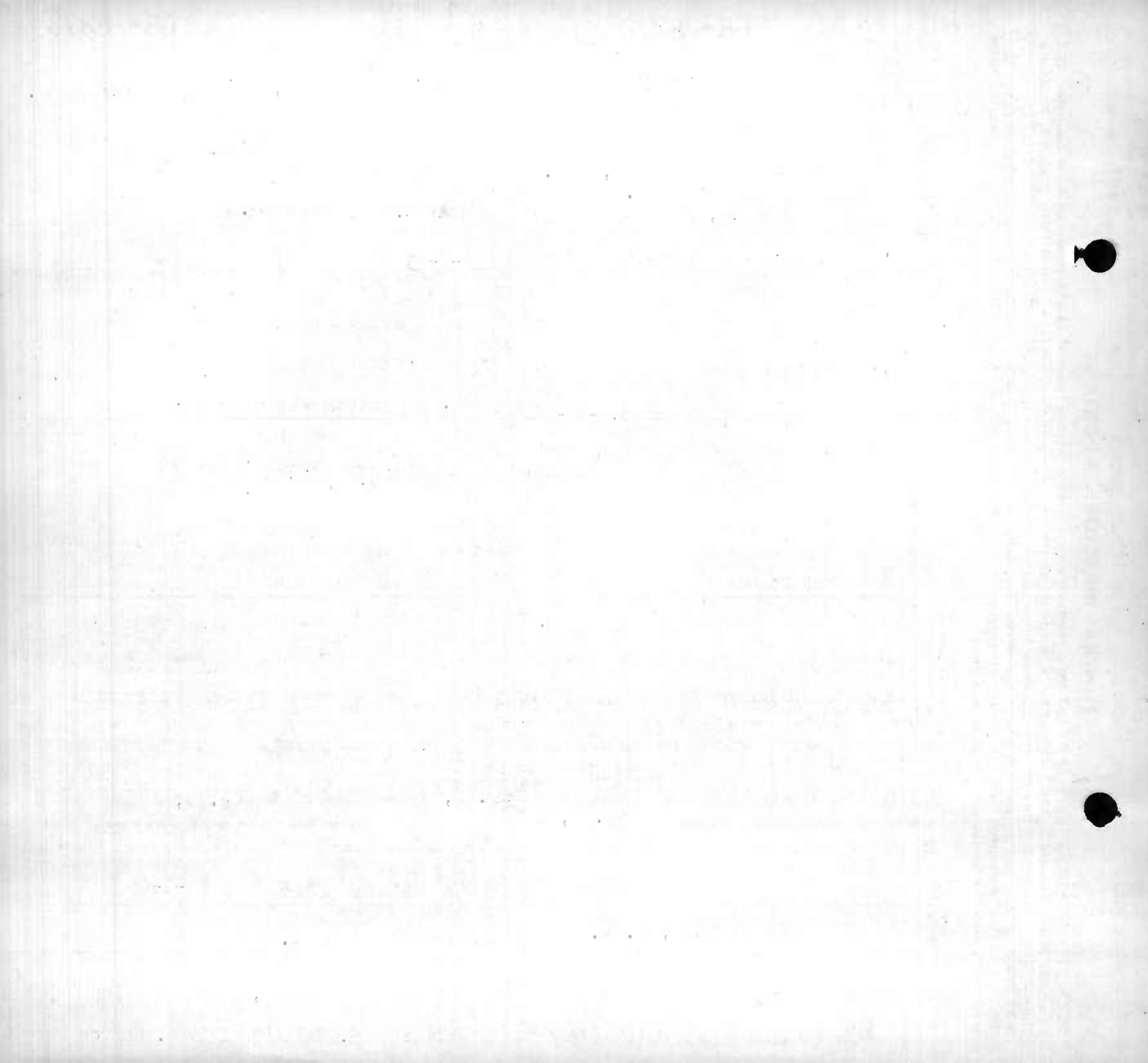
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 68- 8273 CERTIFICATE OF DEATH

REG. NO. 68- 8273

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Youngblood Moore		2. DATE AND HOUR OF DEATH August 9, 1968 9:50 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 1514 Division St. Baltimore, Maryland 21217		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3214 W. Baltimore Street					
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-7-93	9. AGE (In years last birthday) 75	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-18-6361A		17. INFORMANT Mrs. Elizabeth Fletcher (Daughter) Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 436.9 I CAUSE OF DEATH Cerebrovascular Accident		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 2, 1968 to Aug. 9, 1968, that (I) (we) last saw the deceased alive on Aug. 9, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Min Ta Kook, M. D.		23B. DATE SIGNED 8-9-68		23C. PHYSICIAN'S NAME (Type) Min Ta Kook, M. D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 8-10-68		24C. NAME OF CEMETERY or CREMATORY Easley Cemetery	
24D. LOCATION Easley, South Carolina		24E. DATE REC'D BY HEALTH DEPT. AUG 13 1968			
24F. NAME OF REGISTRAR O. L. E. F. J. J. J.		24G. FUNERAL DIRECTOR Arlington S. Phillips 1727 N. Monroe Street			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 8274

BIRTH NO.

67-12534

REG. NO.

1. NAME OF DECEASED  
(Type or Print)

JASON BOYD

(Richard)

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

8

10

68

4:00 a. M.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

August

10

1968

4:00 a. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Balto.

YES ☒NO ☐

E. STREET AND NUMBER

1927 Payson St. (N.)

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF  
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
OR INSTITUTION ADDRESS AND LOCATION)

Sinai Hospital

9-4-68

6. SEX

Male

7. RACE

Colored

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

June 23, 1967

10. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

13

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
USA

13. FATHER'S NAME

Michael Boyd

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Nikie Johnson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Michael Boyd

1927 N. Payson Street

19. 273.01

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

Septicemia with abscesses in liver  
and lungs due to mucoviscidosis (cystic fibrosis)

(A) IMMEDIATE CAUSE

~~Septicemia with abscesses in liver~~

-lungs

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME  
OF INJURY  
(APPROX.)

(Month)

(Day)

(Year)

(Hour)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 10, 1968

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8-13-68

24C. NAME of CEMETERY or CREMATORY

Baltimore National

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

AUG 13 1968

Robert E. Farley

Arlington S. Phillips 1727 N. Monroe Street

Letter from M.E.'s office

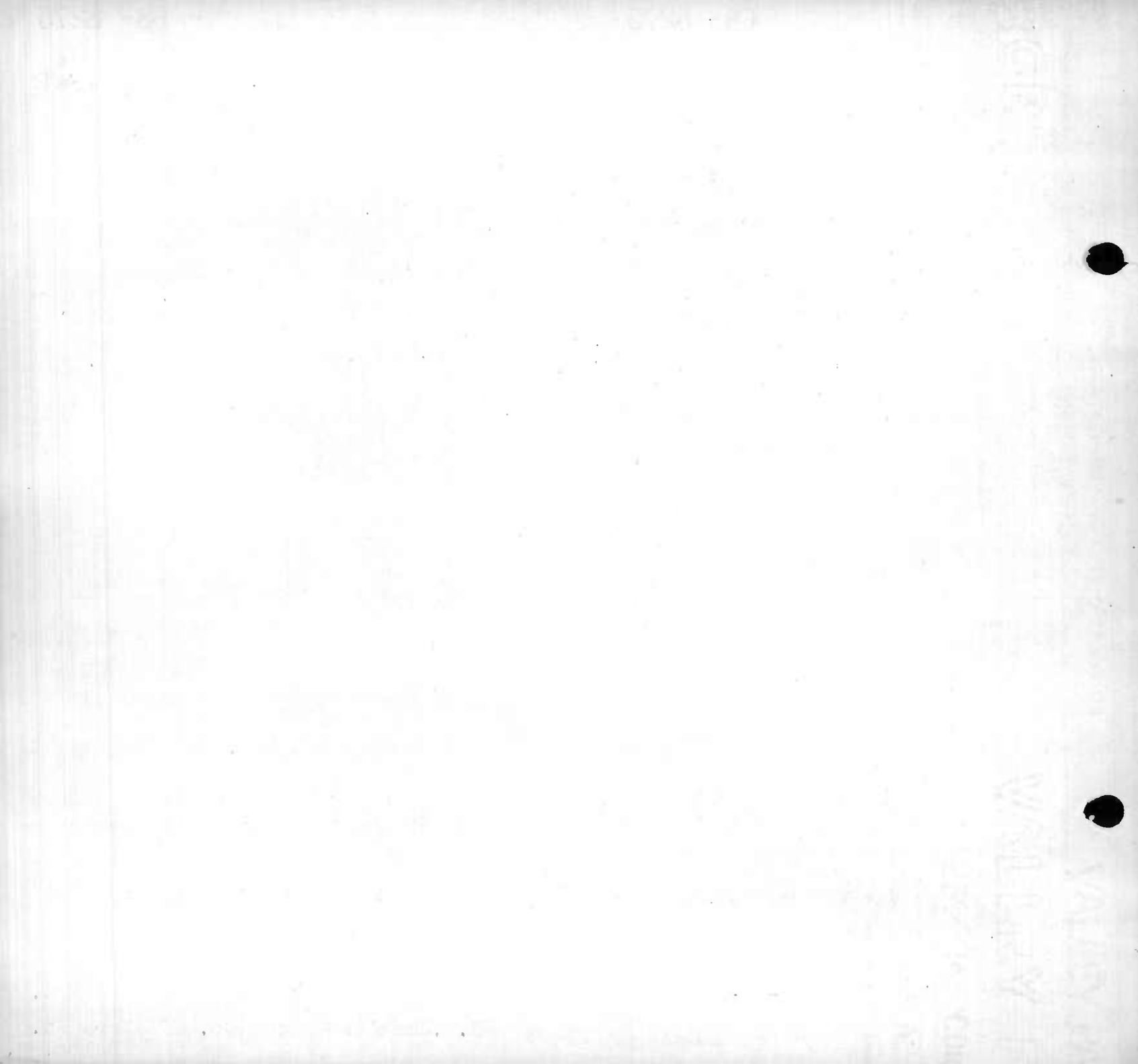
9-4-68

M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		68- 8275	
1. NAME OF DECEASED (Type or Print) <i>Anita Lillian A Staub</i>				2. DATE AND HOUR OF DEATH <i>8/12/68 12:35 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>48 Maryland Gen. Hospital 827 Linden Ave. Baltimore Md. 21201</i>				A. STATE <i>Md.</i>		B. COUNTY <i>27-14</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>101 Ridgewood Road</i>			
5. SEX <i>Female</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <i>11-24-78</i>	9. AGE (In years last birthday) <i>89</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George H. Woodward</i>				14. MOTHER'S MAIDEN NAME <i>Marian</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-46-9069-1</i>		17. INFORMANT <i>Mrs. Isabelle Cogswell</i>		ADDRESS <i>Garrison Md.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>422.1 II</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Congestive Heart Failure</i> (B) <i>A.S.C.V.D.</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>422.1 II</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <i>8-11</i> 19 <i>68</i> to <i>8-12</i> 19 <i>68</i> , that (I) ( <u>we</u> ) last saw the deceased alive on <i>8-12</i> 19 <i>68</i> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Delia C. Gomez, M.D.</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8-12-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>DELIA C. GOMEZ</i>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-15-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Druid Ridge</i>		24D. LOCATION (City, town, or county) (State) <i>Pikesville Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 13 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>H.W. Jenkins &amp; Sons Co.</i>		ADDRESS <i>4905 York Rd. Balto, Md.</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Catherine Adele Moore		2. DATE AND HOUR OF DEATH Aug. 10, 1968 7:15 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1130 E. Belvedere Ave.		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1130 E. Belvedere Avenue		5. SEX F 6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office		10B. KIND OF BUSINESS OR INDUSTRY U.S.F. & G		8. DATE OF BIRTH 2-7-1881 9. AGE (In years last birthday) 87	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles John Scott	
14. MOTHER'S MAIDEN NAME Agnes Broadia		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-07-8025	
17. INFORMANT Miss Helen M. Scott		ADDRESS Same		18. 183,0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ACUTE CONGESTIVE HEART FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. METASTATIC CARCINOMA OF LUNG NOV 1967 SPREAD INTO BLOOD + LYMPH	
19. DATE OF OPERATION 175,0 II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov 7 1967 to Aug 10 1968 that (I) (we) last saw the deceased alive on Aug 10 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George McLean		23B. DATE SIGNED Aug 17-68		23C. PHYSICIAN'S NAME (Type) Dr. George McLean	
23D. ADDRESS Medical Arts Building Balto., Md.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-13-68	
24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Balto., Co. Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 13 1968	
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto., Md. 21212	

8-17-8

Cent. English text for

Nikotinic gumminess of the  
lungs and blood vessels

to

Aug 10

Aug 10

Aug 10

X

Dr. George M. Allen

Dr. George M. Allen

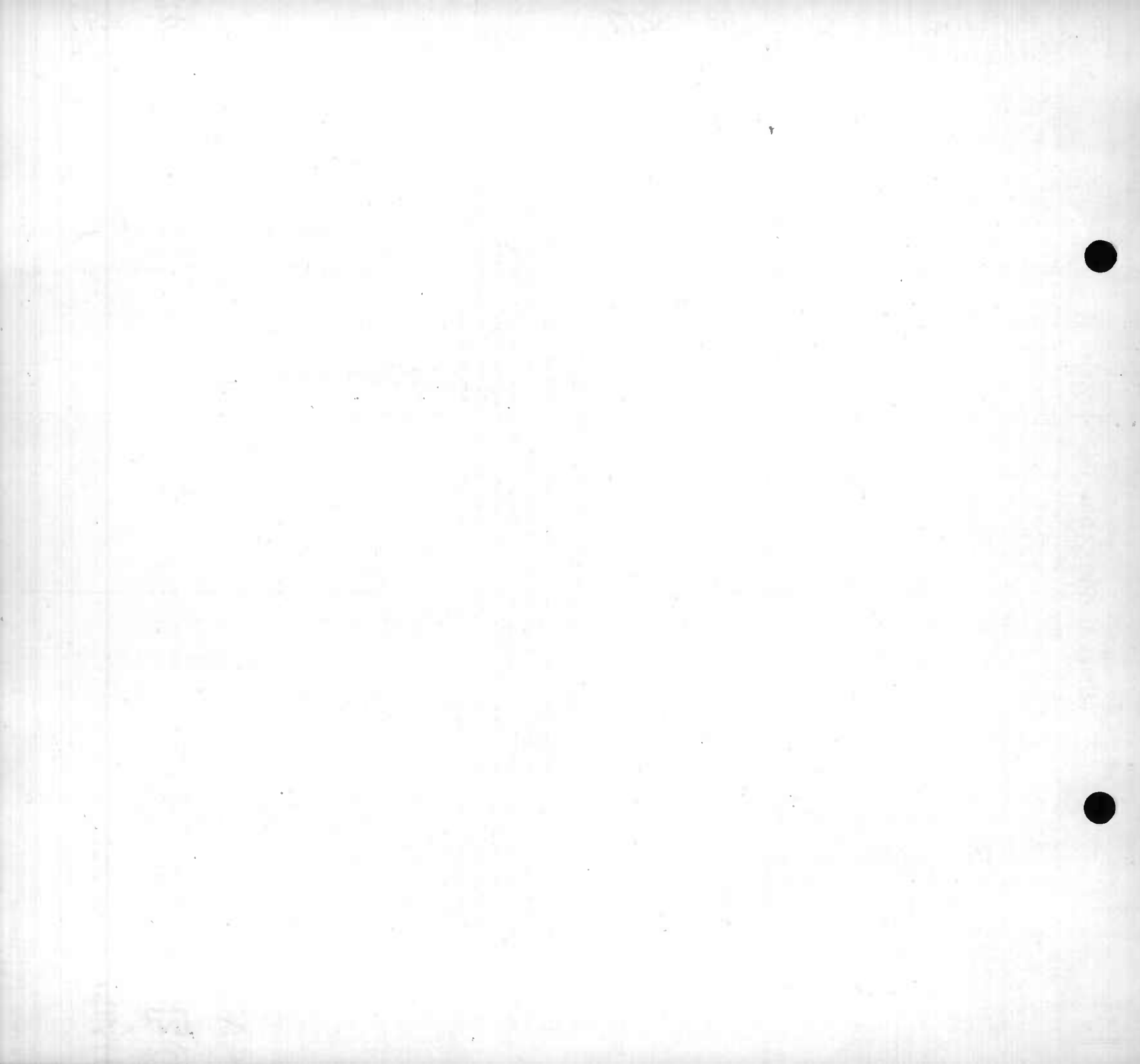
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 8277

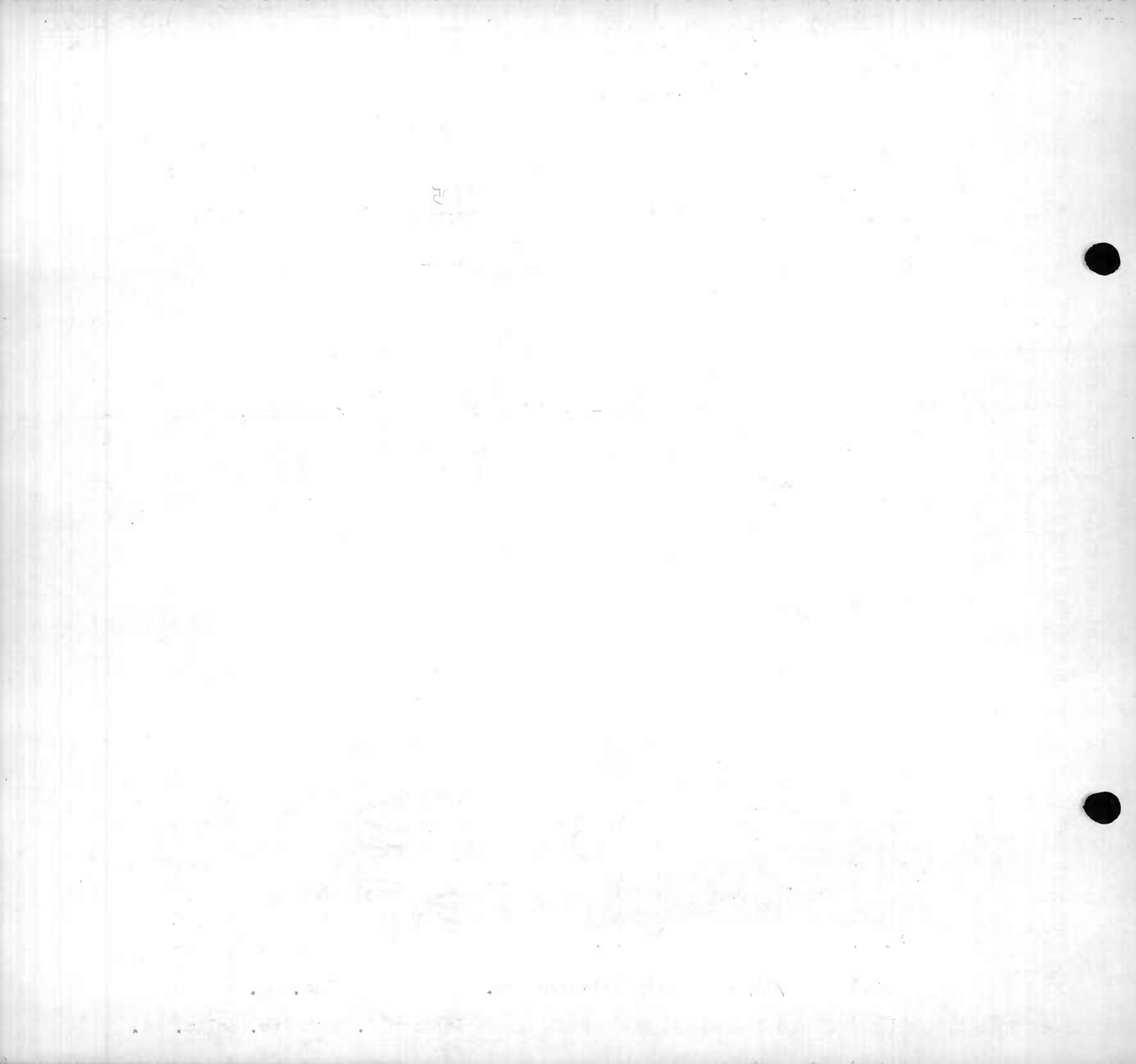
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>SAMUEL D. LONG</b>		2. DATE AND HOUR OF DEATH <b>6:00 PM 8-11-1968</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSP.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> 8. COUNTY <b>9-03</b>		C. CITY OR TOWN <b>BALTIMORE</b>	
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED-FOREMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AMERICAN CAN CO.</b>		8. DATE OF BIRTH <b>3-7-92</b>	
13. FATHER'S NAME <b>LEWIS LONG</b>		14. MOTHER'S MAIDEN NAME <b>LAURA COULTER</b>		9. AGE (In years last birthday) <b>76</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-03-5400</b>		11. BIRTHPLACE (State or foreign country) <b>MD. BALTO.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>331X I</b>		19A. DATE OF OPERATION <b>18-6-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>COIN LESION</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>331X II</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7-4</b> 19 <b>68</b> to <b>8-11</b> 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>8-11</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>DH Brancato, M.D.</b>				23B. DATE SIGNED <b>8-11-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>DH BRANCATO</b>				23D. ADDRESS <b>UNION MEMORIAL HOSP.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-14-68</b>		24C. NAME of CEMETERY or CREMATORY <b>LOUDON PARK</b>	
24D. LOCATION <b>BALTO.</b>		24E. (City, town, or county)		24F. (State) <b>MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>HENRY W. JENKINS &amp; SONS 4905 YORK RD 21212</b>	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

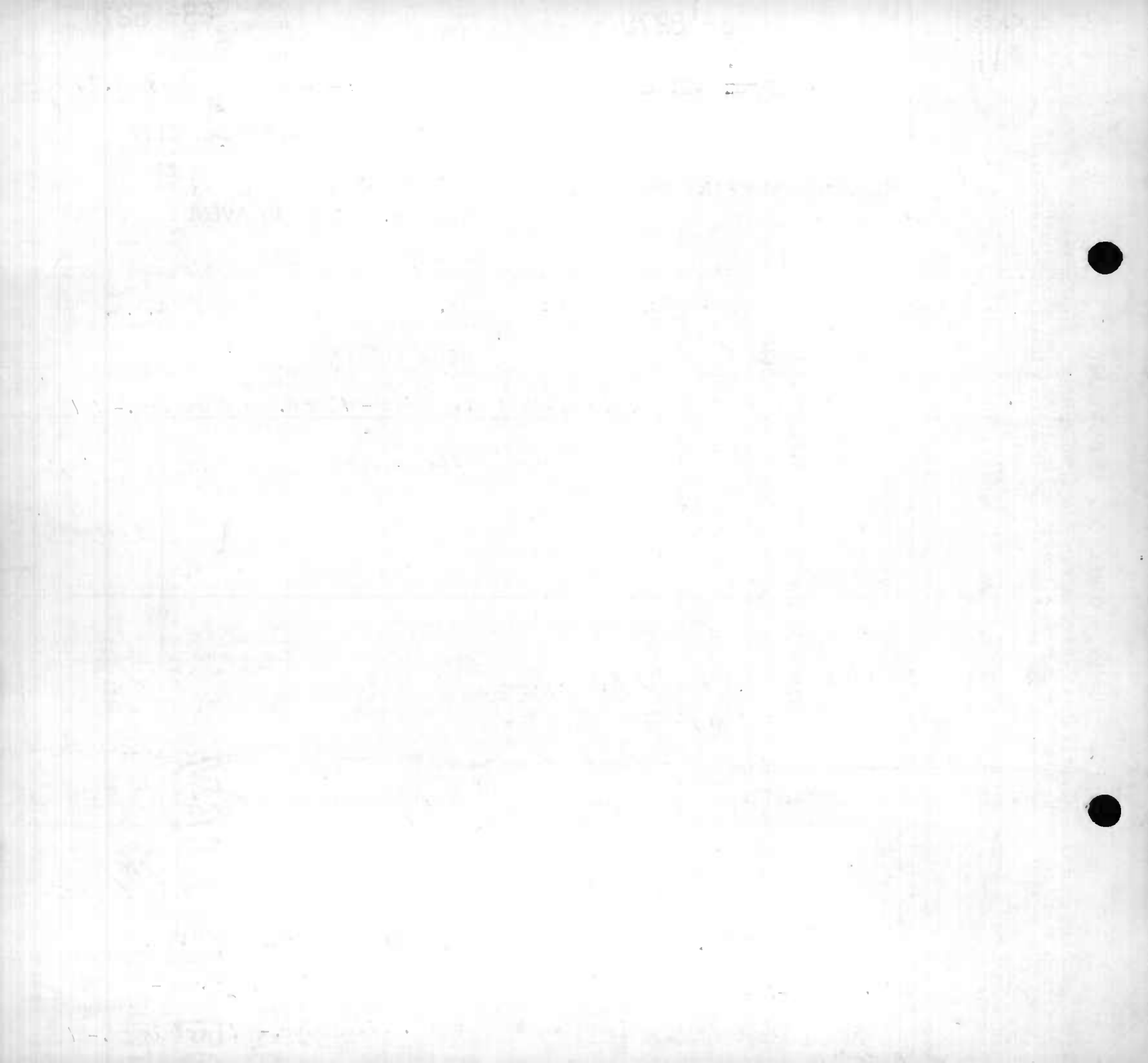
BALTIMORE CITY HEALTH DEPARTMENT				68- 8278		REG. NO.		68- 8278	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Bernard F. McKee</b>				2. DATE AND HOUR OF DEATH <b>8-12-68</b> <b>9:30 a M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>					
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND 21224</b>				C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER <b>4805</b> <b>1606 RENWICK AVENUE 21206</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-20-99</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer Retired</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FRANK McKEE</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH MOORE</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>198-09-9192</b>		17. INFORMANT ADDRESS <b>BCH RECORDS: 4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND 21224</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>1619 I</b> <b>CAUSE OF DEATH</b> <b>LARYNGEAL Carcinoma</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19. DATE OF OPERATION <b>2</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>6-12</b> 19 <b>68</b> to <b>8-12</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8-12</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>R. Christopher Stucky M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>8-12-68</b>			
23C. PHYSICIAN'S NAME (Type) <b>DR. R. CHRISTOPHER STUCKY M.D.</b>				23D. ADDRESS <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE 21224</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/14/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68- 8279	
68- 8279				REG. NO. 68- 8279	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		C. <b>WOLF O. WEISE</b>		8-9-68 1.20 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? <b>YES</b>		
E. STREET AND NUMBER <b>1202 N. MONTFORD AVENUE</b>			F. ZIP CODE <b>21213</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-8-99</b>	9. AGE (In years last birthday) <b>69</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Batch Man</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>American Standard</b>		11. BIRTHPLACE (State or foreign country) <b>Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Samuel Weise</b>		14. MOTHER'S MAIDEN NAME <b>DORA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-12-3079</b>		17. INFORMANT <b>Anna Weise - 1202 N. Montford Ave. - 21213</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>193.0 II</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>5 days</b>	
		(B) <b>Brain Tumor</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>3 months</b>	
		(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>7/22/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Frontal Astrocytoma</b>		20A. AUTOPSY? (Yes or No) <b>yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7/14/68</b> 19 <b>68</b> to <b>8/9</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/9 1:20 AM</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Edward S. Cohn, M.D.</b>				23B. DATE SIGNED <b>8/9/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>EDWARD S. COHN</b>				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-12-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 14 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>John C. Miller Inc. - 6415 Belair Rd. - 21206</b>	
25D. ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

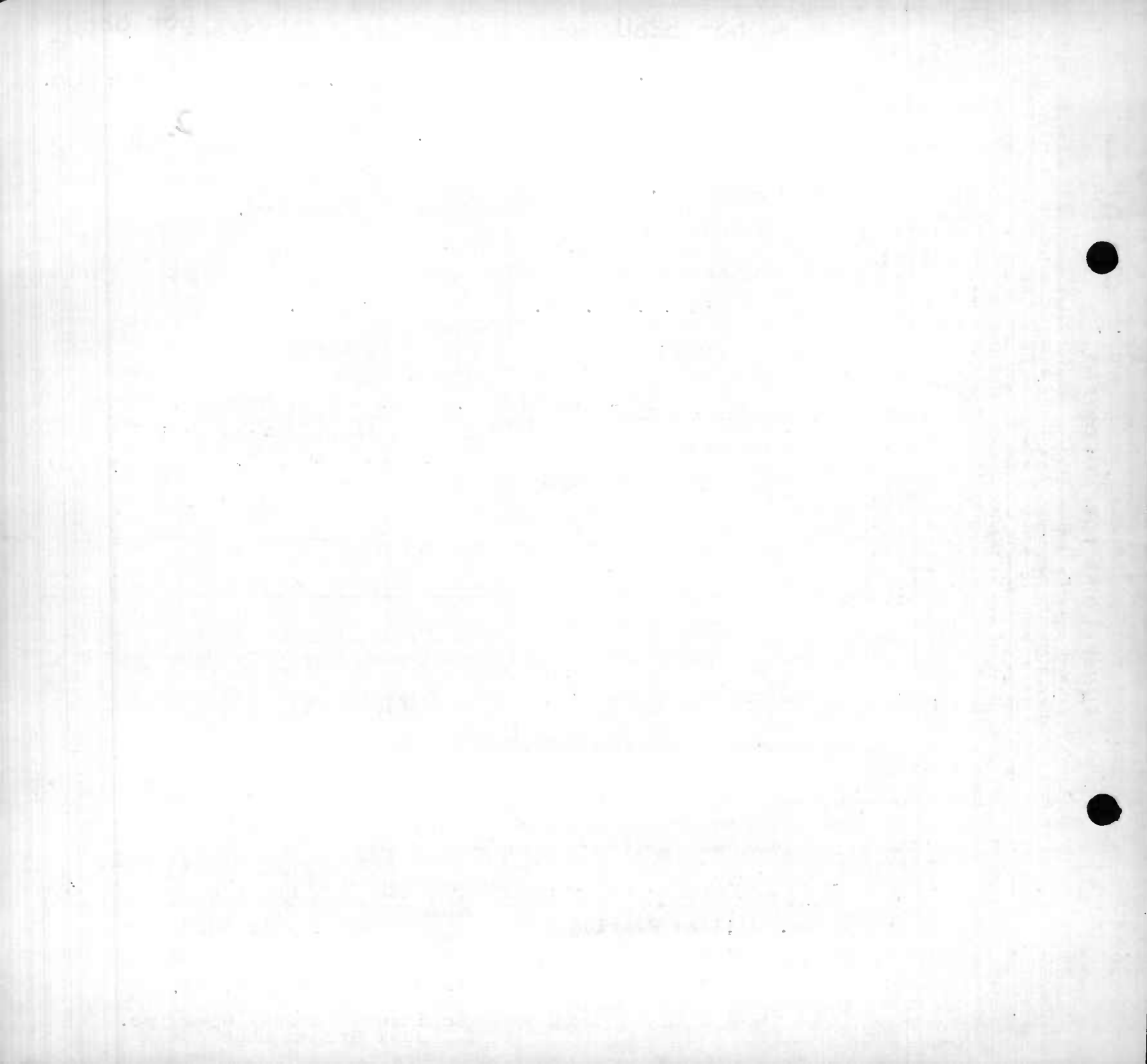
# 68- 8280 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 8280

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MARYANNE V. SMITH		Aug. 8, 1968 10:45 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  2214 E. Lake Ave.				A. STATE Md. 21213	
				B. COUNTY	
				C. CITY OR TOWN	
				Baltimore	
				D. INSIDE CITY LIMITS?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				2214 E. Lake Ave.	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Ooys: If Under 24 Hrs. Min.
female	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1/25/95	73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Clerical		U.S.F. & G. Co.		Baltimore, Md.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Jecny				unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		213-05-8437B		R. Hopper Smith, husband, above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		18 mos.	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
196.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
		Cancer Operative		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from June 15 1965 to August 8 1968, that (I) (we) lost saw the deceased alive on August 6 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
William L Fearing				8-10-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. William Fearing				3025 Belair Road	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/12/68		Loudon Park Cemetery	
				Baltimore, Md.	
25A. DATE RECEIVED		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 14 1968		Robert E. Fearing		Schimunek Funeral Home, Inc. 3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

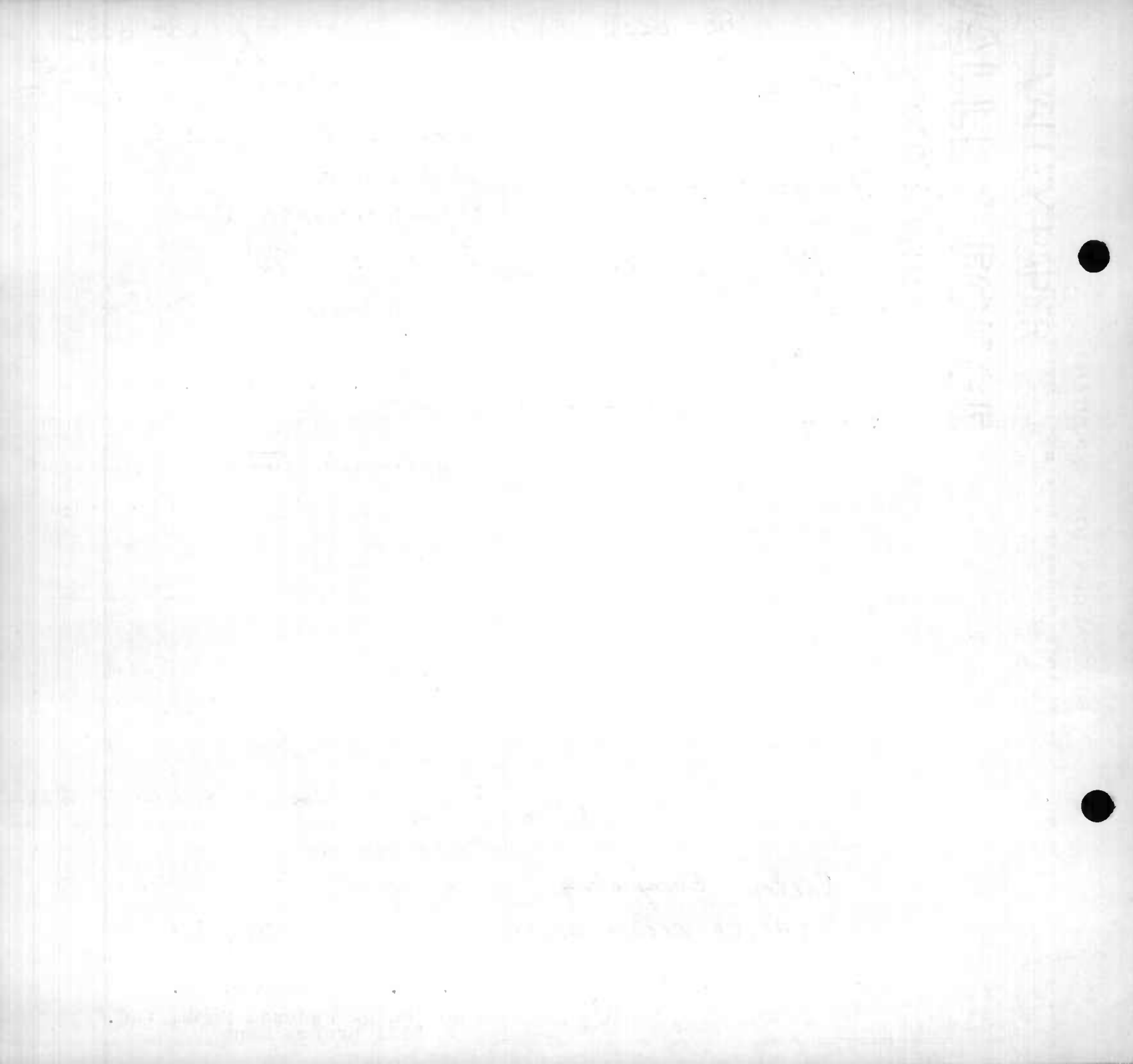
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8281

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 8281

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Waters, Charlotte</i>		2. DATE AND HOUR OF DEATH <i>8-10-68</i> <i>1:30</i> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>21222</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>8132 KAVANAGH Road</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i>			(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-24-93</i>	9. AGE (In years last birthday) <i>75</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Char-lady Wambels Lumber Yard</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore Maryland</i>	
13. FATHER'S NAME <i>Maxmillian Matdorf</i>			14. MOTHER'S MAIDEN NAME <i>unknown</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>220-22-9301A</i>		17. INFORMANT <i>Louis E. Waters, son, above</i> ADDRESS <i>Chart</i>	
18. <i>23919 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Abdominal tumor</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Several wks.</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8/4</i> <i>1968</i> to <i>8/10</i> <i>1968</i> , that (I) (we) lost saw the deceased alive on <i>8/10</i> <i>1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Vallop Boonprakong</i> DEGREE			Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>8/10/68</i>
23C. PHYSICIAN'S NAME (Type) <i>VALLOP BOONPRAKONG</i> DEGREE			23D. ADDRESS <i>Bon Secours Hospital</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>8/13/68</i>	24C. NAME OF CEMETERY or CREMATORY <i>First United Evang. Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE RECEIVED BY HEALTH DEPT. <i>AUG 14 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, Jr.</i>		25C. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i> ADDRESS <i>3331 Brehms Lane</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8282 CERTIFICATE OF DEATH

REG. NO. 68- 8282

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Walter Mrs. Ada E.</u>		2. DATE AND HOUR OF DEATH <u>8-10-68</u> <u>11:25 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>BALTIMORE</u> B. COUNTY <u>Md.</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? <u>6</u> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>CHURCH HOME AND HOSPITAL</u> <u>100 N. Broad way.</u> <u>35 BALTIMORE MD 21231</u>		E. STREET AND NUMBER <u>107 N. Milton ave.</u>			
5. SEX <u>female</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-2-1900</u>	9. AGE (In years last birthday) <u>68 Yr.</u>	If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - wife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Woolworth Stores</u>		11. BIRTHPLACE (State or foreign country) <u>MD, weona</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Malvin Collier</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Jackson</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>212-12-009</u>		17. INFORMANT <u>Dr. P. A. V. K. Rao</u>	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Bilateral Basilar Pneumonia</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>terminal cancer</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Several days.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) <u>Carcinoma of Pancreas.</u>		<u>1 year.</u>	
(C) _____					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>157X II</u>					
19A. DATE OF OPERATION <u>7-12-68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Exploratory Laparotomy</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>6-23-1968</u> to <u>8-10-1968</u> , that (we) last saw the deceased alive on <u>8-10-1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>K. V. Narasimhan</u>		23B. DATE SIGNED <u>8-10-68</u>			
23C. PHYSICIAN'S NAME (Type) <u>P. A. V. K. R. ISHVARAO</u> <u>(Dr. GARLICK)</u>		23D. ADDRESS <u>CHURCH HOME AND HOSPITAL</u> <u>BALTIMORE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/14/68</u>		24C. NAME of CEMETERY or CREMATORY <u>Gardens of Faith Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 14 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>	
25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>		25D. ADDRESS			

1-4-5-10-15-20-25-30-35-40-45-50-55-60-65-70-75-80-85-90-95-100

1-2-3-4-5-6-7-8-9-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100

1-2-3-4-5-6-7-8-9-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100

1-2-3-4-5-6-7-8-9-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100

1-2-3-4-5-6-7-8-9-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100

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1-2-3-4-5-6-7-8-9-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100

1-2-3-4-5-6-7-8-9-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8283 CERTIFICATE OF DEATH

REG. NO.

68- 8283

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Rose Wickes</i>		2. DATE AND HOUR OF DEATH <i>8-8-68</i> <i>1:38 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>6-05</i>		C. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>5 Church Home + Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>March 19, 1887</i>		9. AGE (In years lost birthday) <i>81</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School teacher</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Annapolis, Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13. FATHER'S NAME <i>Roscoe Wickes</i>		14. MOTHER'S MAIDEN NAME <i>Anne Wayman</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <i>203X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Multiple Myeloma</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>days</i> <i>month</i>	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <i>Feb. 15</i> 19 <i>68</i> to <i>8-8</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>8-8</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>[Signature]</i>		23B. DATE SIGNED <i>8-8-68</i>		23C. PHYSICIAN'S NAME (Type) <i>D. A. E. SUBONIS, MD</i>	
23D. ADDRESS <i>Church Home + Hospital</i>		23E. ADDRESS <i>Church Home + Hospital</i>		23F. ADDRESS <i>Church Home + Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>8-9-68</i>		24C. NAME OF CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county)		24E. LOCATION (City, town, or county)		24F. LOCATION (City, town, or county)	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 14 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, MD</i>		25C. FUNERAL DIRECTOR ADDRESS <i>MORTUARY SERVICE - BCHD</i>	

1881

100 N. Broadway  
New York

Prof. W. I. King

University of Wisconsin  
Madison

Dear Sir

Yours

W. I. King

No

1881

W. I. King

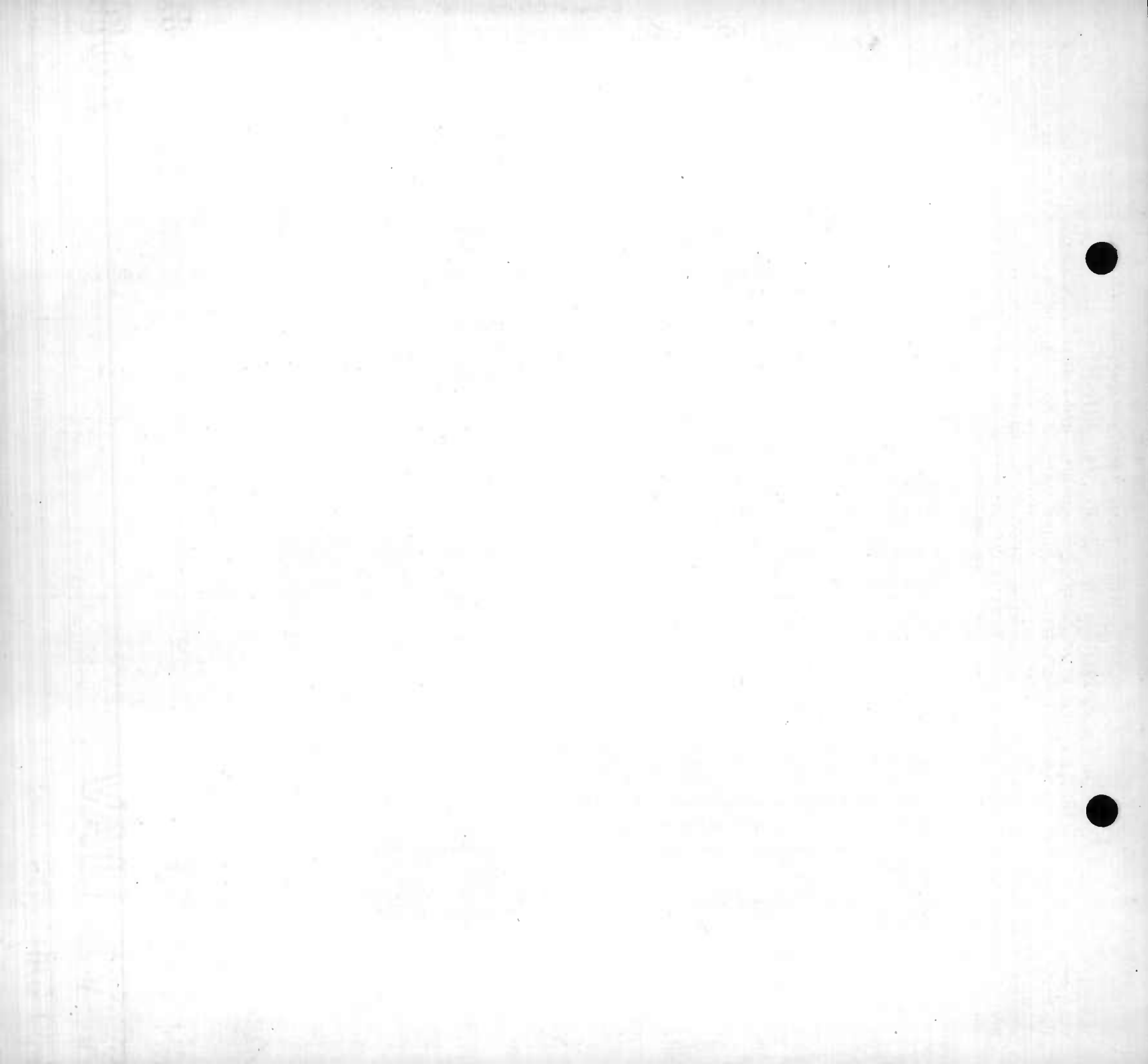
100 N. Broadway

New York

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

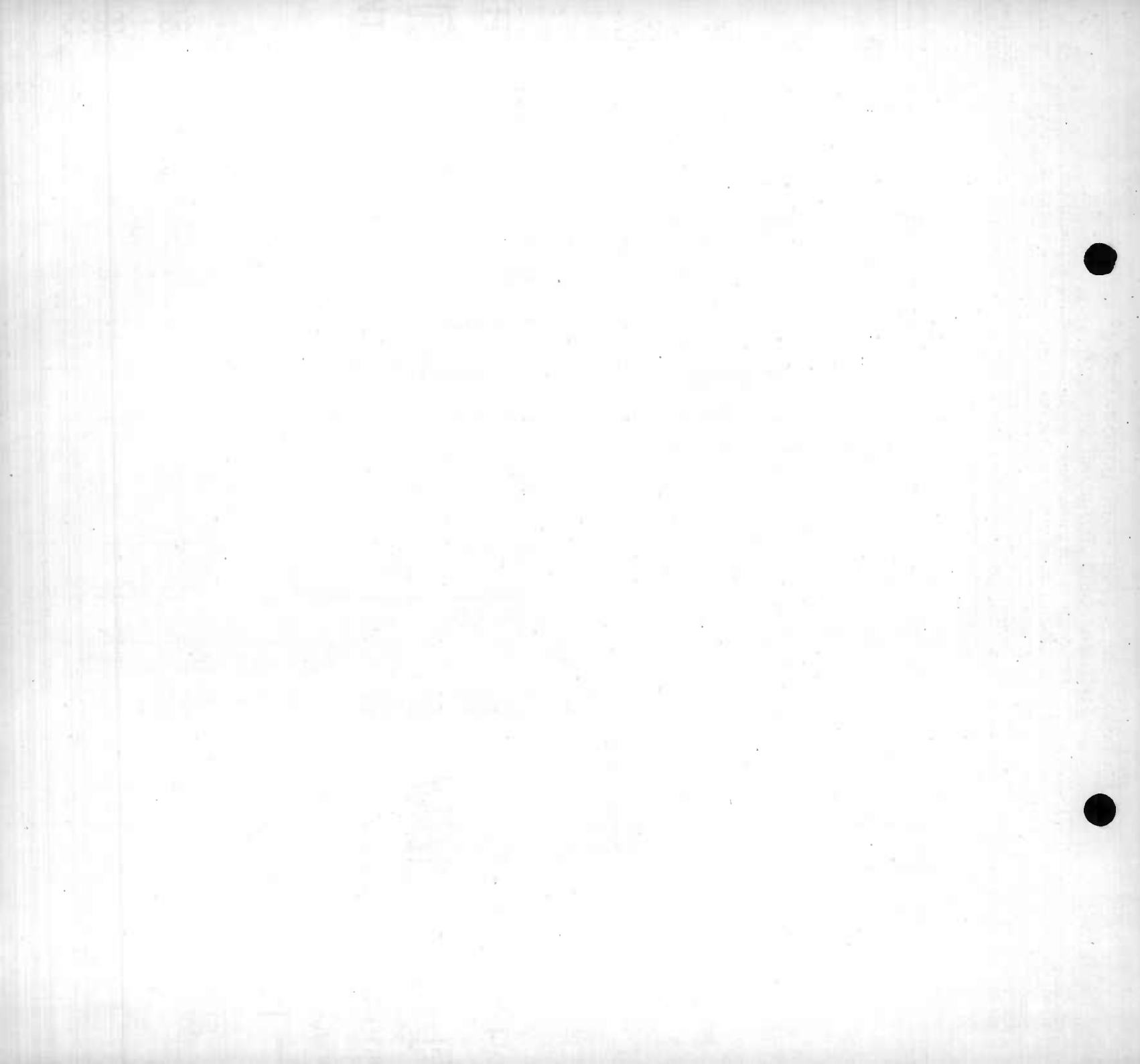
BIRTH NO. <b>68-14363</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>68- 8284</b> <b>CERTIFICATE OF DEATH</b>		REG. NO. <b>68- 8284</b>	
1. NAME OF DECEASED (Type or Print) <b>BABY GIRL RICHARDSON</b>			2. DATE AND HOUR OF DEATH <b>AUGUST 4 1968 4:40 P.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LUTHERAN HOSPITAL OF MARYLAND</b> <b>46</b>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>15-38</b> C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2400 ELSINORE AVE.</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. <b>10</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <b>WEBSTER RICHARDSON</b>			14. MOTHER'S MAIDEN NAME <b>ETHEL HAWKINS</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>chart</b>	
18. <b>777X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Prematurity</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 hrs.</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>AUG 4 1968 4:40 PM</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>AUG. 4, 1968</b> to <b>AUG. 4 1968</b> , that (I) (we) last saw the deceased alive on <b>AUG. 4 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Vilma F. Padalar MD</b>			23B. DATE SIGNED <b>8/4/68</b>		
23C. PHYSICIAN'S NAME (Type) <b>VILMA F. TA</b>			23D. ADDRESS <b>Lutheran Hospital of Maryland</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>8-9-68</b>		24B. DATE		24C. NAME of CEMETERY or CREMATORY <b>UNIVERSITY MEDICAL SCHOOL</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 14 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, MD</b>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8285
BIRTH NO. 68-13907		68- 8285 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Baby Boy DAVIS		2. DATE AND HOUR OF DEATH 7-27-68 11:30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 7-05		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital of Md. 46		C. CITY OR TOWN BAITO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER 613 N. Bond ST.		
5. SEX Male	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-26-68	9. AGE (In years lost birthday) 36 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) md.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME DANIEL DAVIS		
14. MOTHER'S MAIDEN NAME mary myers.		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT char		
18. 777X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Generalized Premature 36 hrs. DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from July 26, 19 68 to July 27, 19 68, that (I) (we) last saw the deceased alive on July 27, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Ludilina M. Oteyza				23B. DATE SIGNED July 27, 1968
23C. PHYSICIAN'S NAME (Type) LUDILINA M. OTEYZA				23D. ADDRESS LUTHERAN HOSPITAL, BALTIMORE, MD.
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8-9-68		24C. NAME OF CEMETERY or CREMATORY ANATOLY BOARD OF MARYLAND
24D. LOCATION		UNIVERSITY MEDICAL SCHOOL		
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1968		25B. NAME OF REGISTRAR Rene E. Faldy		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCDP



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

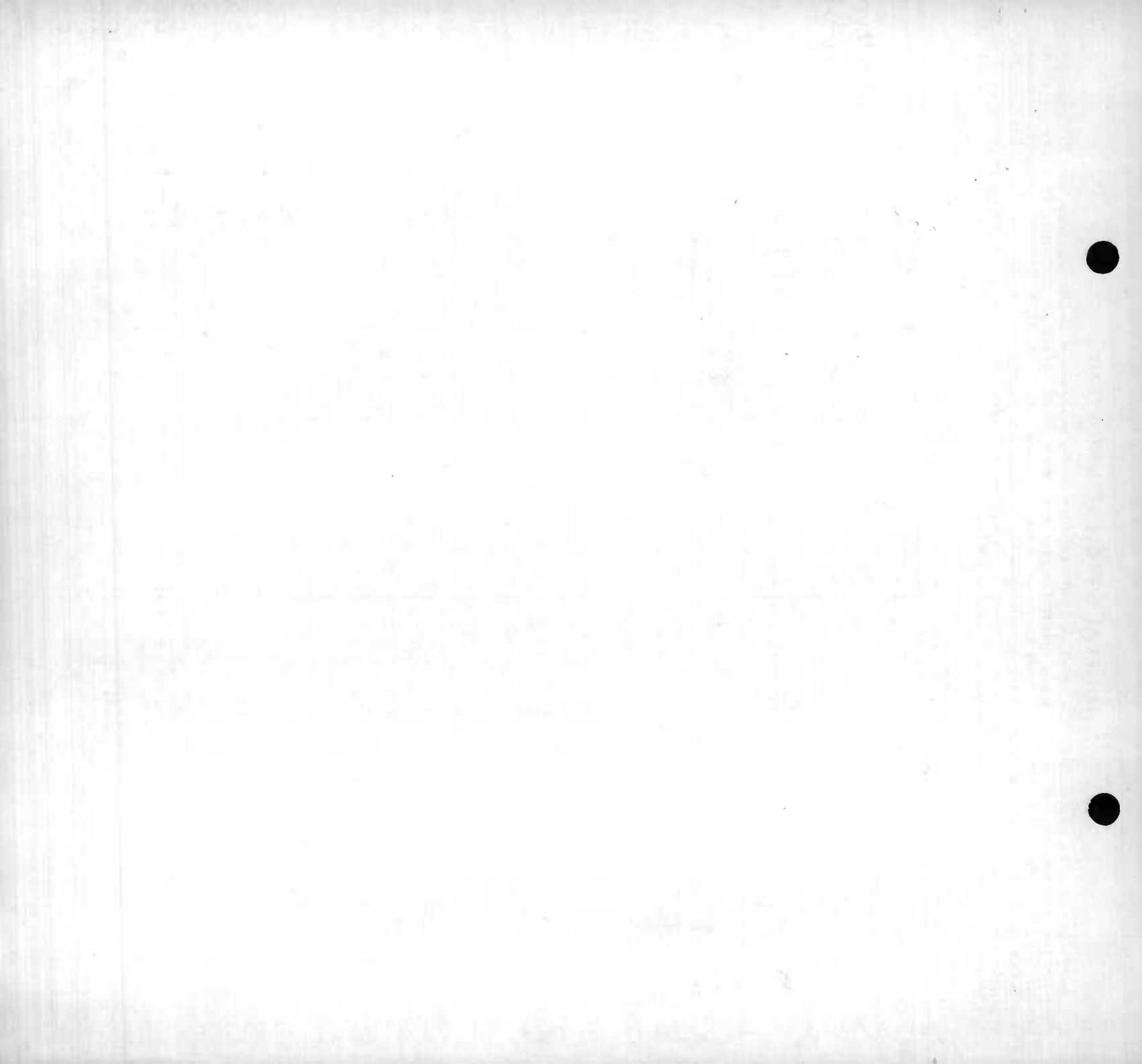
BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 8286 4

BIRTH NO. 68-14586 68- 8286 CERTIFICATE OF DEATH

1. NAME OF DECEASED (Type or Print) <u>Baby Ray Tambusch</u>		2. DATE AND HOUR OF DEATH <u>8/6/68</u> <u>9:10 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>New born</u> B. COUNTY <u>Maryland</u> <u>21238</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General</u> <u>43</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? <u>YES</u> <u>NO</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>1311 Cooksie St.</u>	
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/6/68</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <u>-</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>George Frank Gisin</u>		14. MOTHER'S MAIDEN NAME <u>Kathleen Tambusch</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mother</u>		ADDRESS <u>1311 Cooksie St # 30</u>	
18. <u>777X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Immaturity</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____	
19. <u>776X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>Yes</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 8</u> 19 <u>68</u> to <u>Aug 8</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Aug 8</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Frank A. Kulik, MD</u>		23B. DATE SIGNED <u>8/6/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Frank A. Kulik</u>		23D. ADDRESS <u>South Baltimore General Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <u>8-9-68</u>	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 14 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>	
25C. FUNERAL DIRECTOR		ADDRESS	
<u>MORTUARY SERVICE - BCHD</u>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8287

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ROLAND A. WATTS

2. DATE  
OF DEATHKnown ☐ Estimated ☒

Month

Day

Year

Hour

August 12, 1968

6:00 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
OR INSTITUTION ADDRESS OR LOCATION)

562 S. Longwood Street

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

August 12, 1968

6:40 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

male

7. RACE

white

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

Oct. 25, 1909

10. AGE (In years  
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

562 S. Longwood St.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

WILLIAM WATTS.

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

STONE KEEPER

14B. KIND OF BUSINESS OR INDUSTRY

GROCERY

15. MOTHER'S MAIDEN NAME

GERTRUDE BROOKS

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

NONE

17. SOCIAL  
SECURITY NO.

?

18. INFORMANT

ADDRESS

MARIE WATTS 562 S. Longwood ST.

19. E 966 X

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

Multiple Stab Wounds

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

E 982 X II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

home

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

562 S. Longwood St. 20-06

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.) 8/12/68 6:00 P. m.

22E. INJURY OCCURRED

WHILE AT  
WORK ☒NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

subj. stabbed during robbery

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/13/68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

8-16-68

24C. NAME OF CEMETERY or CREMATORY

LONDON PARK

24D. LOCATION (City, town, or county)

BALTIMORE, Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 14 1968

25B. NAME OF REGISTRAR

Robert E. Spitz, M.D.

25C. FUNERAL DIRECTOR

GEO. L. Schwab Funeral Home  
Francis W. Miller 2101 Frederick Ave

1052-20

1052-20

1052-20

1052-20

1052-20

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1052-20

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>EDWARD WILLIAM KRAMER</b>				2. DATE AND HOUR OF DEATH <b>8/10/68</b> <b>11<sup>20</sup> A.M.</b>				68- 8288			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>UNIVERSITY OF MD. HOSP.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Baltimore</b>				53-00			
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 BALTO. MD.</b>				C. CITY OR TOWN <b>BALTIMORE</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <b>2645 FURNELL DRIVE</b>							
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-13-05</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COMMERCIAL ARTIST</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>				11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>William Kramer</b>				14. MOTHER'S MAIDEN NAME <b>LILLIE PEPPLER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 11</b>				16. SOCIAL SECURITY NO. <b>YES</b>				17. INFORMANT <b>Estelle Houck-2601 Larchmont Drive 21207</b>			
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL INFARCTION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>10 days</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>420.1 II</b>											
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 1, 1968</b> to <b>AUGUST 10, 1968</b> , that (I) <del>was</del> lost saw the deceased alive on <b>AUGUST 10, 1968</b> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>We</del> (did) (did not) view the body after death.											
23A. SIGNATURE <b>Darryl. Wilmer MD.</b>								23B. DATE SIGNED <b>8/10/68</b>			
23C. PHYSICIAN'S NAME (Type)								23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)								24B. DATE		24C. NAME of CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county) (State)											
25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 14 1968</b>								25B. NAME OF REGISTRAR <b>Robert E. Tachy</b>		25C. FUNERAL DIRECTOR <b>Ellsworth Armacost-4600 Liberty Hghts. Ave.</b>	

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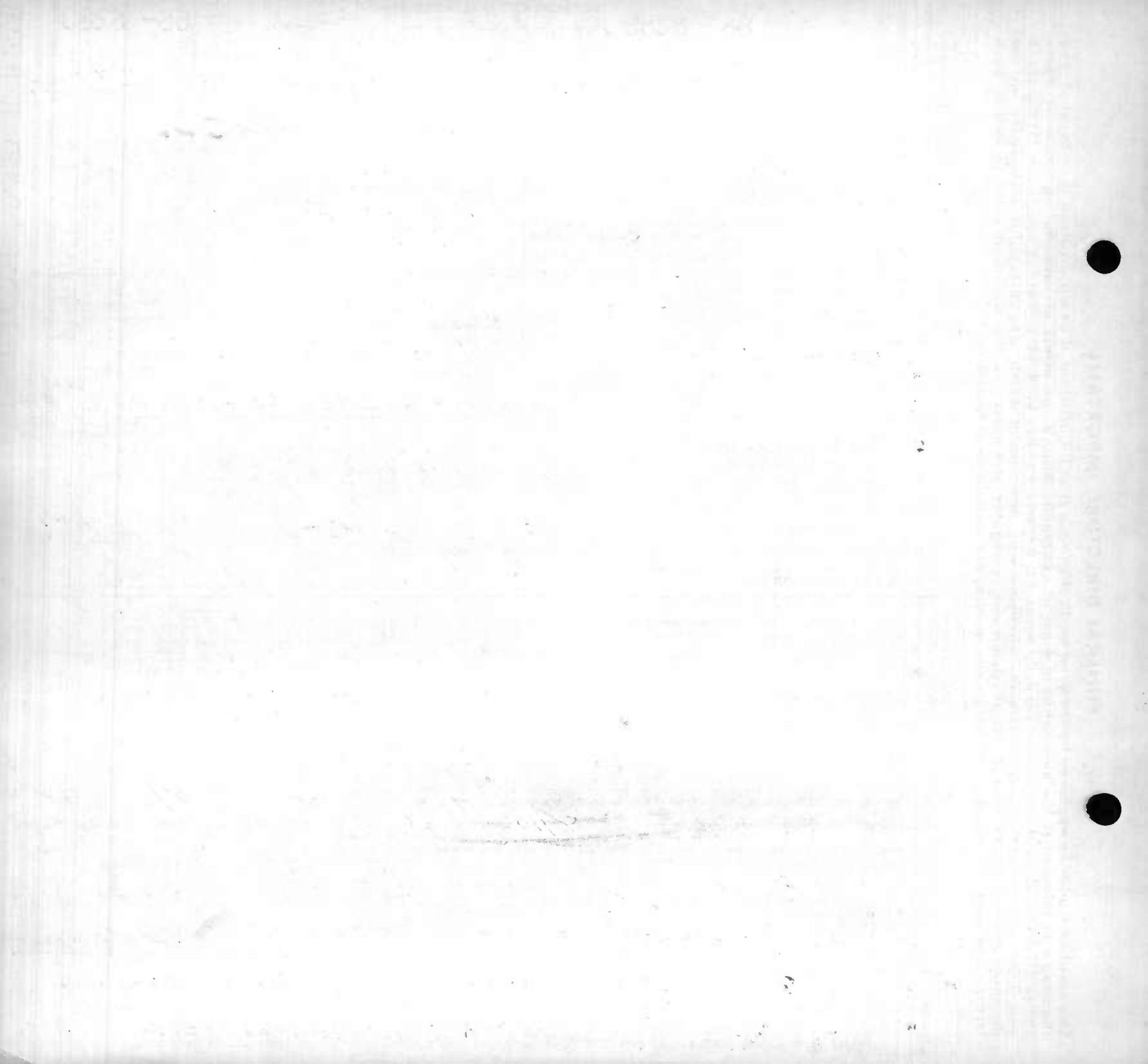
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 68- 8289 CERTIFICATE OF DEATH

REG. NO. 68- 8289

BIRTH NO.		1. NAME OF DECEASED. (Type or Print) <b>Walter Krass</b>		2. DATE AND HOUR OF DEATH <b>8/11/68 @ 2 45 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Bolton Hill Hosp. &amp; Convalescent Home, Inc.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1-02</b>		
5. SEX <b>Male</b>			6. RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>7/28/98</b>		9. AGE (In years last birthday) <b>70</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BAKER</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Food</b>		11. BIRTHPLACE (State or foreign country) <b>PENN.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>John Krass</b>		
14. MOTHER'S MAIDEN NAME <b>Louise Zaranek</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>215-12-2812-A</b>			17. INFORMANT <b>JULIA ANZULEWICZ</b>		
ADDRESS <b>21206 4600 Ridgeway Ave.</b>			18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>16211</b> <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>cardiovascular</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>CA / lung</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>arteriosclerosis generalized</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs.</b> <b>7/64</b> <b>years</b>		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>163X II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7/28</b> 19 <b>68</b> to <b>8/11</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/10</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>ALLAN H. MACHT</b>				23B. DATE SIGNED <b>8/11/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALLAN H. MACHT MD</b>				23D. ADDRESS <b>2 E. READ ST BALTIMORE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-13-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>ST. Stanislaus</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 14 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>Nicholas T. Matthews</b>			
ADDRESS <b>3021 EASTERN AVE.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-215		68- 8290		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 8290	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
				ISADORE FISHBEIN			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH			
				Aug. 12, 1968 12:45 A. M.			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY			
33 The Johns Hopkins Hospital				Maryland Baltimore			
				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
				Baltimore 1-05 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				1921 McElderry St.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10-10-94	73			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Ladies Tailor		Tailoring		Russia		21-S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Abraham Fishbein				Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
		214-03-4471		Henry Vogel		3704 Glen Ave Bttr	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
153.8 I				CARDIO-RESPIRATORY FAILURE			
ANTECEDENT CAUSES				(B) DIFFUSE G-I BLEEDING TENDENCY - (LIFETIME)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				DUODENUM ULCER MULTIPLE (35-40) BLOOD TRANSFUSIONS			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
7/17/68		CARCINOMA OF COLON		YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
NO							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (this hospital) attended the deceased from July 16, 1968 to August 12, 1968, that (I) lost saw the deceased alive on August 12, 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Vernon T. Tolo, M.D.				Aug. 12, 1968			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Vernon T. Tolo, M.D.				The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8-13-68		Wingard Lodge Cem		Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 14 1968		Robert E. Taylor		Jack Lewis Inc. 2100 Eutan Pl.			

12-12-1942

12-12-1942

M W

John T. Taylor  
Cleveland, Ohio

2143-4111 (Long 3704)

Case - 12-12-1942

12-12-1942

12-12-1942

12-12-1942

12-12-1942

12-12-1942

12-12-1942

12-12-1942

12-12-1942

12-12-1942

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8291

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 8291

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WEISS, FREDERIC</b>		2. DATE AND HOUR OF DEATH <b>AUGUST 12, 1968 11:55 AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>40 ST. AGNES HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION		E. STREET AND NUMBER <b>7800 LIBERTY RD. 21207</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>06/14/92</b>	9. AGE (in years last birthday) <b>76</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SELF EMPLOYED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MD TRANSPORTATION</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>HENRY WEISS</b>		14. MOTHER'S MAIDEN NAME <b>NELLIE PELTZ WEISS</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NONE</b>		16. SOCIAL SECURITY NO. <b>212-16-8180A</b>		17. INFORMANT <b>ST. AGNES HOSPITAL</b>	
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebro-vascular accident</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arterio-sclerotic cerebro-vascular disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. <b>422.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 11 1968</b> to <b>AUGUST 12 1968</b> , that (I) (we) last saw the deceased alive on <b>AUGUST 12 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Charles R. Fehs</b>		23B. DATE SIGNED <b>08/12/68</b>		23C. PHYSICIAN'S NAME (Type) <b>CATON &amp; WILKENS AVES. ST. AGNES HOSP; BALTO, MD 21229</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 15, 68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Providence Met. Cem</b>	
24D. LOCATION (City, town, or county) (State) <b>Gamber Maryland</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 14 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fehs</b>	
25C. FUNERAL DIRECTOR <b>Loring Byers</b>		25D. ADDRESS <b>8728 Liberty Rd. 21133</b>			

Check - record account

Antoine - record account

Antoine & Co

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-1621		68- 8292		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 68- 8292	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
		REHBERG, SISTER ANGELA				AUGUST 13, 1968		8:10A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				MARYLAND		28-41	
40 ST. AGNES HOSPITAL						C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
						E. STREET AND NUMBER 4000 FOREST HILL RD. 21207			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		01/10/89		79			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
RELIGIOUS				Rochester, N.Y.		U.S.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
CASPAR RHEBERG				MARY ANN CASTELLO RHEBERG					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NONE		219-54-0069-J1		ST. AGNES HOSPITAL RECORDS					
18. 410.9 I		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CARDIOGENIC SHOCK.							
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES		ACUTE MYOCARDIAL INFARCTION							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:							
		ASCVD							
		(C) POSSIBLE CVA				12 HOURS			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from		AUGUST 11		19 68 to		AUGUST 13		19 68	
that (I) (we) last saw the deceased alive on		AUGUST 13		19 68		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED							
<i>Alexander Mejia</i>		08/13/68							
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. FUNERAL DIRECTOR		23F. ADDRESS			
A. MEJIA, M.D.		BALTIMORE, MD 21229		ST. AGNES HOSP; CATON & WILKENS AVES.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
burial		8-14-68		Seton		Baltimore-21215			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS			
AUG 14 1968		Robert E. Taylor, M.D.		Stewart & Mowen Co.		108-W-North-Av-21201			

ST. JAMES HOSPITAL RECORDS

MARY ANN CATTALDO MESSERS

ST. JAMES HOSPITAL RECORDS

CARDIOLOGIC THICK

ST. JAMES HOSPITAL RECORDS

ACCO

POTENTIAL CAN

NO

ST. JAMES HOSPITAL RECORDS

AUGUST 18

ST. JAMES HOSPITAL RECORDS

ST. JAMES HOSPITAL RECORDS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		68- 8293		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68- 8293	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
William Harrison Mullen				August 12, 1968 1:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
90 Gould Convalescent Home				Maryland			
				C. CITY OR TOWN (If outside city limits, write R.U.R.A. and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				5730 Fenwick Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
Male	White	Widower	Feb. 10, 1883	85			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Supervisor-ret.		Retail store		New York		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Albert Mullen				Mary M. Green			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		None		577-01-6415		Family records	
18. 153.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
				Cachexia			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Impure diet			
153.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Aug 10 19 68 to Aug 12 19 68, that (I) (we) last saw the deceased alive on August 11 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Albert B. Bradley						8/13/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
ALBERT B. BRADLEY,				4900 BELAIR ROAD BALTO., MD. 21206			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Aug. 14, 1968		Ft. Lincoln Cemetery		Washington, D.C.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 14 1968		Robert E. Sander		John Burns' Sons, Towson, Md.			



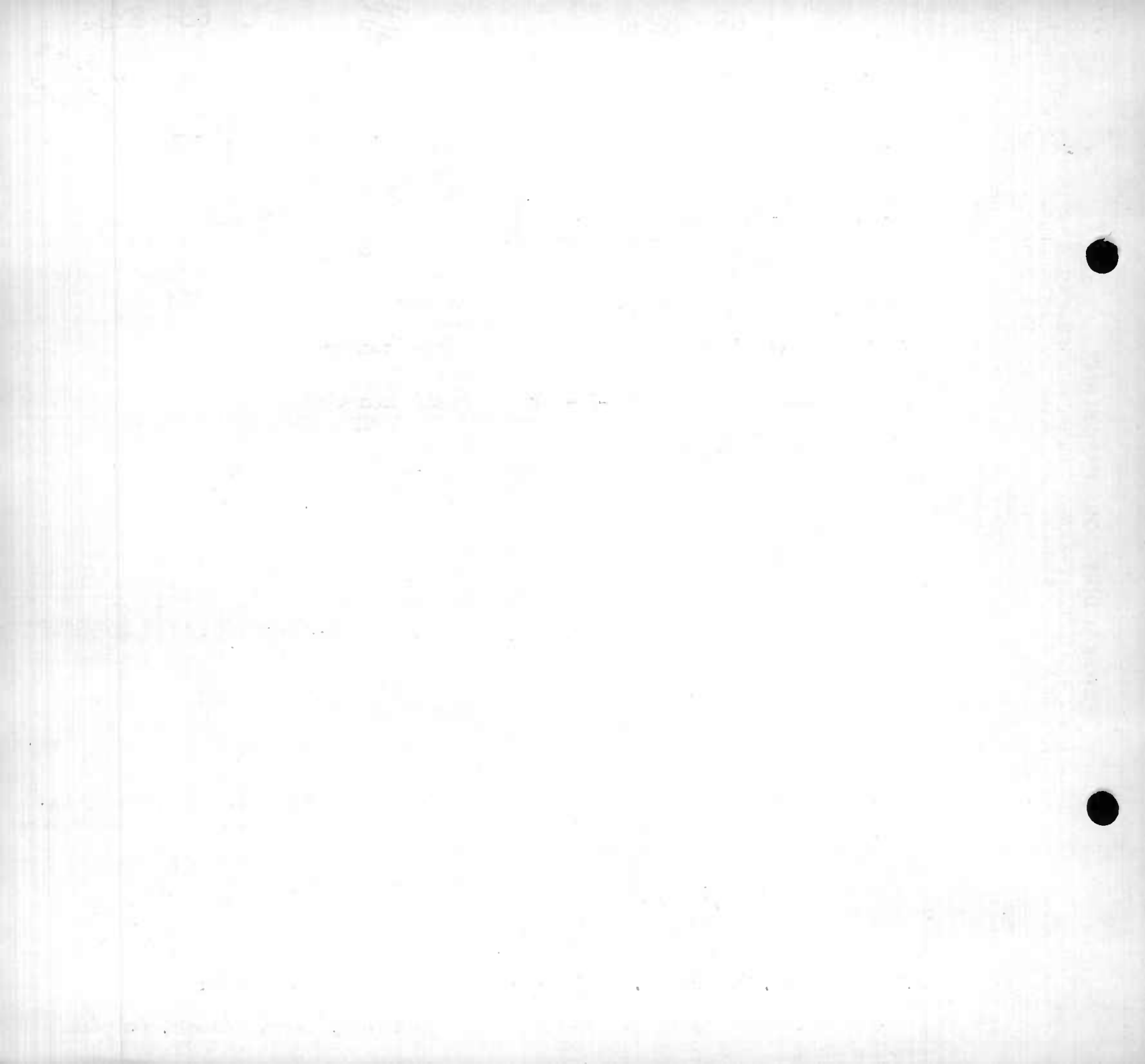
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8294 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 68- 8294

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ROGERS Miss JANE F.</b>		2. DATE AND HOUR OF DEATH <b>August 11 1968 4<sup>15</sup> p.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> 8. COUNTY <b>9-05</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>34 Bon Secours Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>842 GORSUCH AVE</b>		5. SEX <b>F</b> 6. RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 18 1902</b> 9. AGE (In years last birthday) <b>65</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>IBM Repair Shop</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SECRETARY</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Rogers</b>		14. MOTHER'S MAIDEN NAME <b>Mary Creaghan</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No None</b>	
16. SOCIAL SECURITY NO. <b>217-18-0684</b>		17. INFORMANT <b>Family records</b>		ADDRESS	
18. <b>485 X-1</b> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Bronchopneumonia, bilateral</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>491X II Villous adenoma of rectum weeks</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>Aug. 6th 1968</b> to <b>Aug. 11th 1968</b> , that (1) (we) last saw the deceased alive on <b>4:10 pm 8/11 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b> DEGREE				23B. DATE SIGNED <b>8-11-68</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>Bon Secours Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 14, 1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Marie Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Towson, Maryland</b>		(State)			
25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 14 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>	
ADDRESS					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-8295
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Inley, Blanche E.</b>		2. DATE AND HOUR OF DEATH <b>8/7/68</b> <b>730</b> P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>4 Union Memorial Hospital.</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>3206 St Paul St.</b>				
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/25/89</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		9. AGE (in years last birthday) <b>79</b>
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Robert Pearson.</b>		14. MOTHER'S MAIDEN NAME <b>Mary Wesley Steward.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>48 81 70</b>		17. INFORMANT <b>chart of patient - by patient</b>
18. <b>436.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>pneumonia -&gt; septicemia</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>dehydration</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>CVA</b> (C) <b>Page + s. Disease</b>		
19. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>No</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>No</b>
21D. TIME OF INJURY (APPROX.) <b>No</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <b>No</b>		21F. HOW DID INJURY OCCUR? <b>No</b>
22. I certify that (1) (this hospital) attended the deceased from <b>Aug 1</b> 19 <b>68</b> to <b>Aug 7</b> 19 <b>68</b> , that (1) (we) last saw the deceased alive on <b>Aug 8</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Brian Block</b>		23B. DATE SIGNED <b>Aug 7, 1968</b>		
23C. PHYSICIAN'S NAME (Type) <b>BRIAN BLOCK</b>		23D. ADDRESS <b>Union Memorial</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 10, 1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Dorchester Memorial Park, Cambridge, Md.</b>
24D. LOCATION (City, town, or county) (State) <b>Dorchester</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 14 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fathman</b>		25C. FUNERAL DIRECTOR <b>Kenneth R. Thomas</b>
25D. ADDRESS <b>Cambridge, Md.</b>				

宣  
武

— 225 —

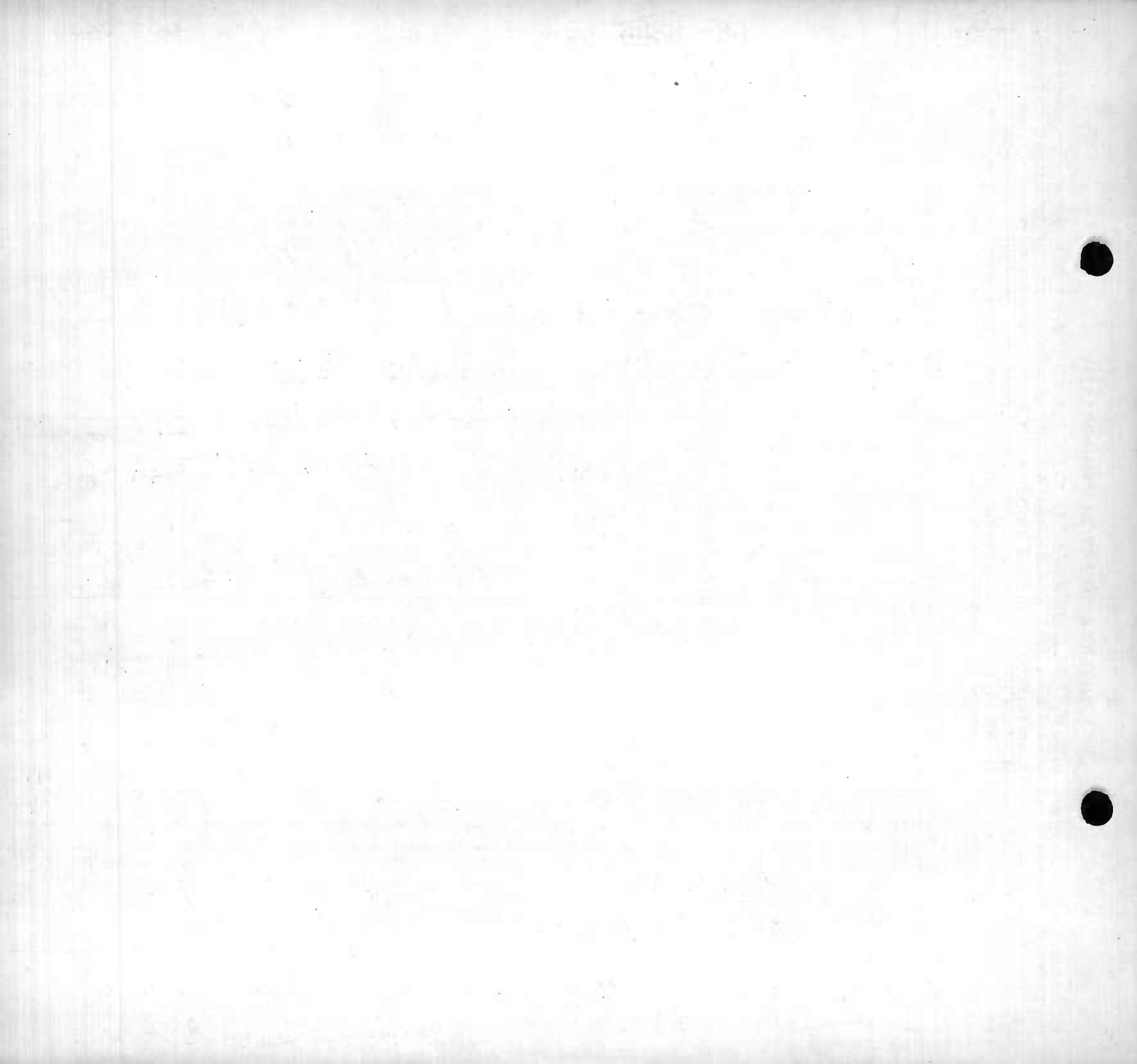
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8296 CERTIFICATE OF DEATH

REG. NO. 68- 8296

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BENJAMIN BRISCOE</b>		2. DATE AND HOUR OF DEATH <b>8/9/68 11:00 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>37 Mercy Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>FOU 80N</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>301 LENNOX AVE</b>	
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/14/18</b>	9. AGE (in years last birthday) <b>50</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CUSTODIAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>LOYOLA HIGH SCHOOL</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>RANDOLPH BRISCOE</b>			14. MOTHER'S MAIDEN NAME <b>DORA REID</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215183378</b>		17. INFORMANT <b>MRS BARBARA BANKINS HOLLYWOOD, MD</b>	
18. <b>400.1 I</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>PULMONARY EMBOLISM</b> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>C.H.F.</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Malignant Hypertension</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>441X II</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/8</b> 19 <b>68</b> to <b>8/9</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/9</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>8/10/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>SAMI BRADY</b>		23D. ADDRESS <b>[Address]</b>			
24A. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-13-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>ST. PETER CLAVER CEM.</b>	
24D. LOCATION (City, town, or county) (State) <b>RIDGE, MARYLAND</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 14 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jackson, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Robinson Funeral Home</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT

# 68- 8297 CERTIFICATE OF DEATH

REG. NO.

68- 8297

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ANNIE E. POIST

2. DATE AND HOUR OF DEATH

8/9/68

4:20 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSP. BALTIMORE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

ANNE ARUNDEL CO

52.00

C. CITY OR TOWN

SAVAGE

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

101 BALTIMORE ST.

5. SEX

F

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

7/29/15

9. AGE (In years lost birthday)

53

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

WM. B. REELEY

14. MOTHER'S MAIDEN NAME

ESTHER POISE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

MR. T. POIST

ADDRESS

ABOVE

18. 174 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

METASTATIC CARCINOMA OF BREAST 2YRS.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

170 X II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

D

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/9 19 68 to 8/9/68 19 that (I) (we) lost saw the deceased alive on 4:20 PM 8/9/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Jerome L. Rubin M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

8/9/68

23C. PHYSICIAN'S NAME (Type)

JEROME L. RUBIN

M.D.

23D. ADDRESS

JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-13-68

24C. NAME OF CEMETERY or CREMATORY

Meadowdale Memorial Park Danvers Md

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 14 1968

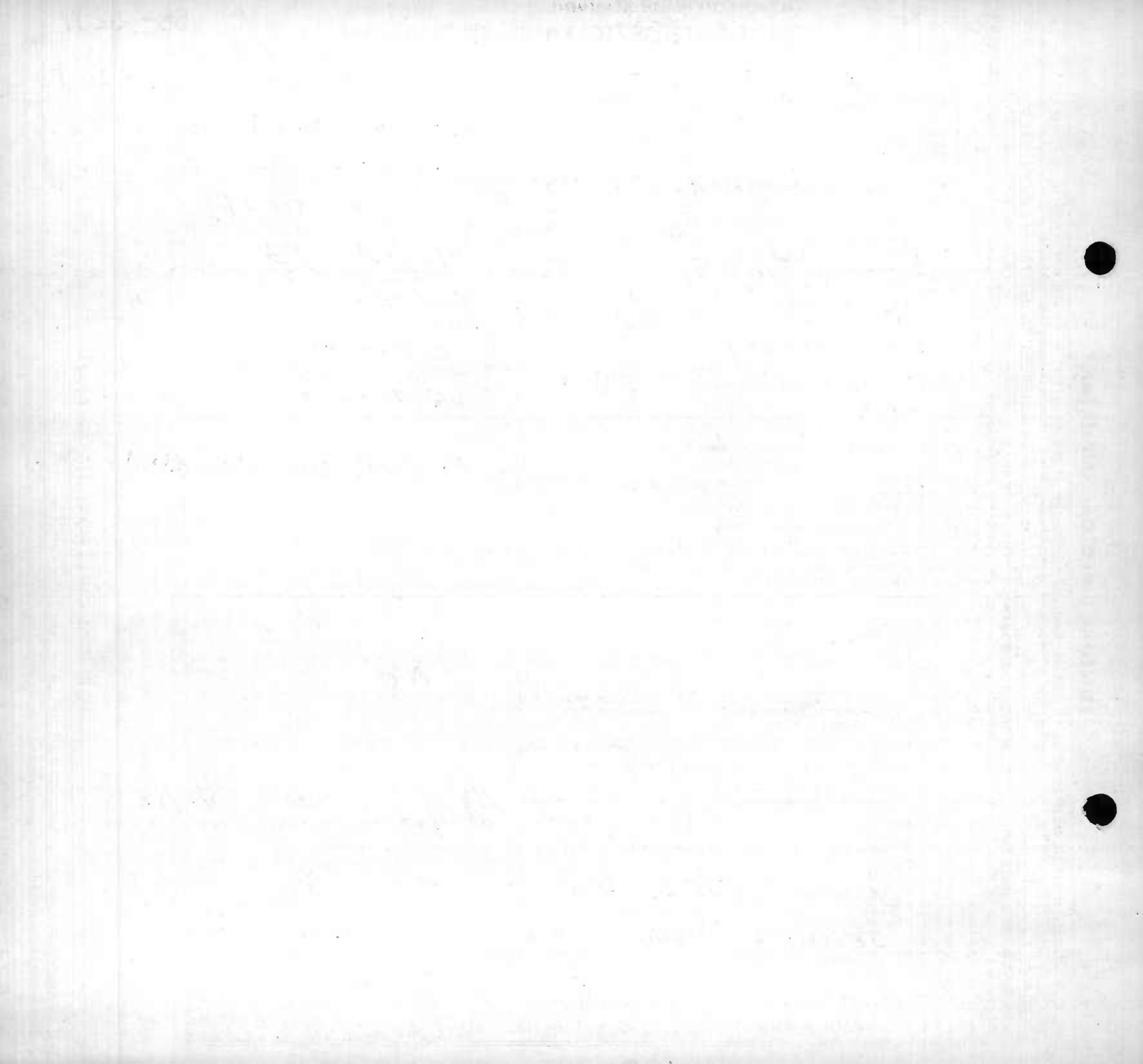
25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Danielson Funeral Home Laurel Md

ADDRESS



BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Leona Mavis

2. DATE AND HOUR OF DEATH

6:45pm 8-9-68

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Ave.

Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

3818 Forrester Ave. # 21206 007

5. SEX

Female

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

4-1-98

9. AGE (In years  
last birthday)

70

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Pettis Dec.

14. MOTHER'S MAIDEN NAME

Anna Dippel Dec.

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

215-54-3060

17. INFORMANT

Records

BCH: 4940 Eastern Ave. Baltimore, Maryland

ADDRESS

# 21224

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

260 X II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 4-26-1968 to 8-9-1968.  
that (I) (we) lost saw the deceased alive on 8-9-1968 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

R. Chris Stucky MD.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

8-9-68

23C. PHYSICIAN'S  
NAME (Type)

R. Chris Stucky MD.

DEGREE

23D. ADDRESS

Baltimore City Hospitals  
4940 Eastern Ave. Baltimore, Maryland #2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8/13/68

24C. NAME OF CEMETERY or CREMATORY

Loudon Park Cemetery

24D. LOCATION

(City, town, or county)

Balto

(State)

25A. DATE RECEIVED IN HEALTH DEPT.

AUG 14 1968

25B. NAME OF REGISTRAR

Robert E. Tanbury

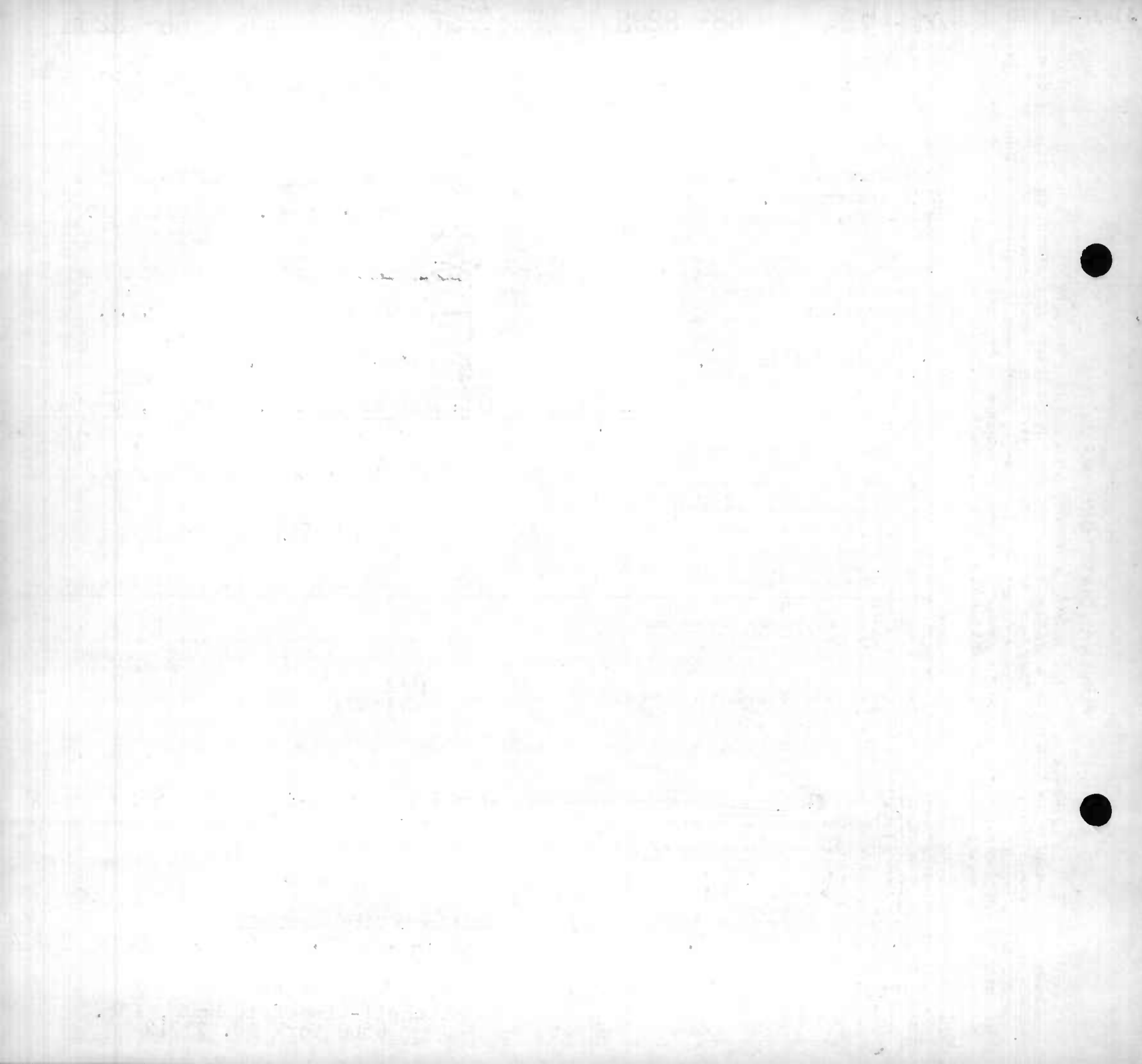
25C. FUNERAL DIRECTOR

Mitchell-Wiedefeld Home, Inc.  
6500 York Rd. 21212

ADDRESS

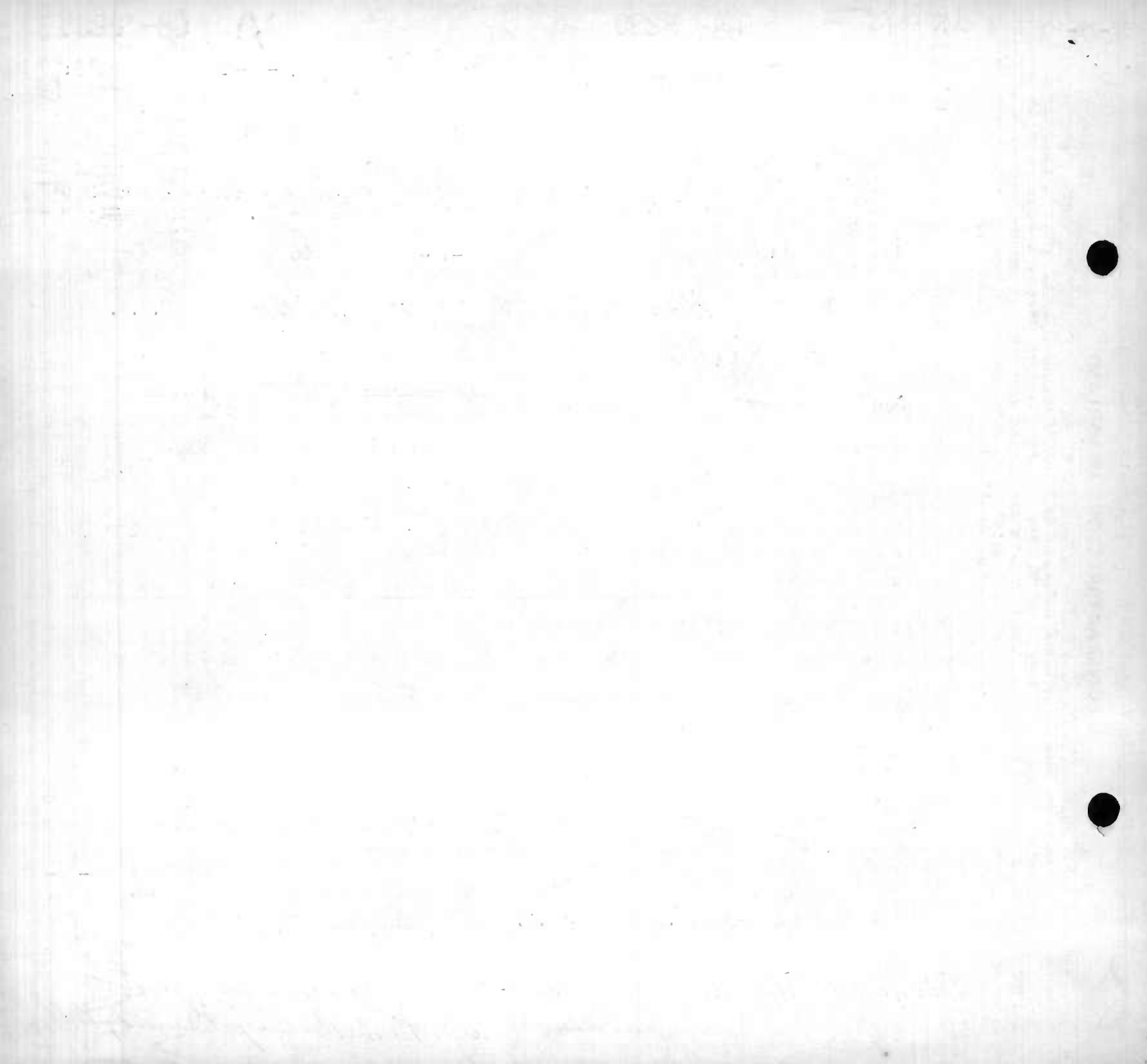
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	68-8299
1. NAME OF DECEASED (Type or Print)		FRANK A. KLING		2. DATE AND HOUR OF DEATH 8-12-68 3:20 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND BALTIMORE		53-00	
BALTIMORE CITY HOSPITALS		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
31 4940 EASTERN AVENUE		DUNDALK		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
BALTIMORE, MARYLAND 21224		E. STREET AND NUMBER		F. STREET AND NUMBER	
		1619 FOUR BRIDGES CT. 21222		GEORGE'S HOLABIRD EAST, APTS. 005	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
M MALE	W WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8-10-02	66	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
MACHINIST		AIR CRAFT MFGR		MARYLAND PENNA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
FRANK A. KLING		ELIZABETH DURBIN		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		215-09-6859 A		BCH Records: 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		? CARDIAC ARREST / HYPOTENSION		FEW HRS	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		METASTATIC TRACHEAL CA.		2 YEARS	
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
1620 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-21-1968 to 8-12-1968, that (I) (we) last saw the deceased alive on 8-12-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Lee J. Cordova M.D.		8/12/68		LEE J. CORDOVA M.D.	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. ADDRESS	
LEE J. CORDOVA M.D.		BALTIMORE CITY HOSPITALS 21224		4940 Eastern Balt MD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
CREMATION		8/13/1968		GREENMOUNT	
25A. DATE RECEIVED		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 14 1968		Robert E. Tarkenton		Lee J. Cordova, Dundalk, MD	



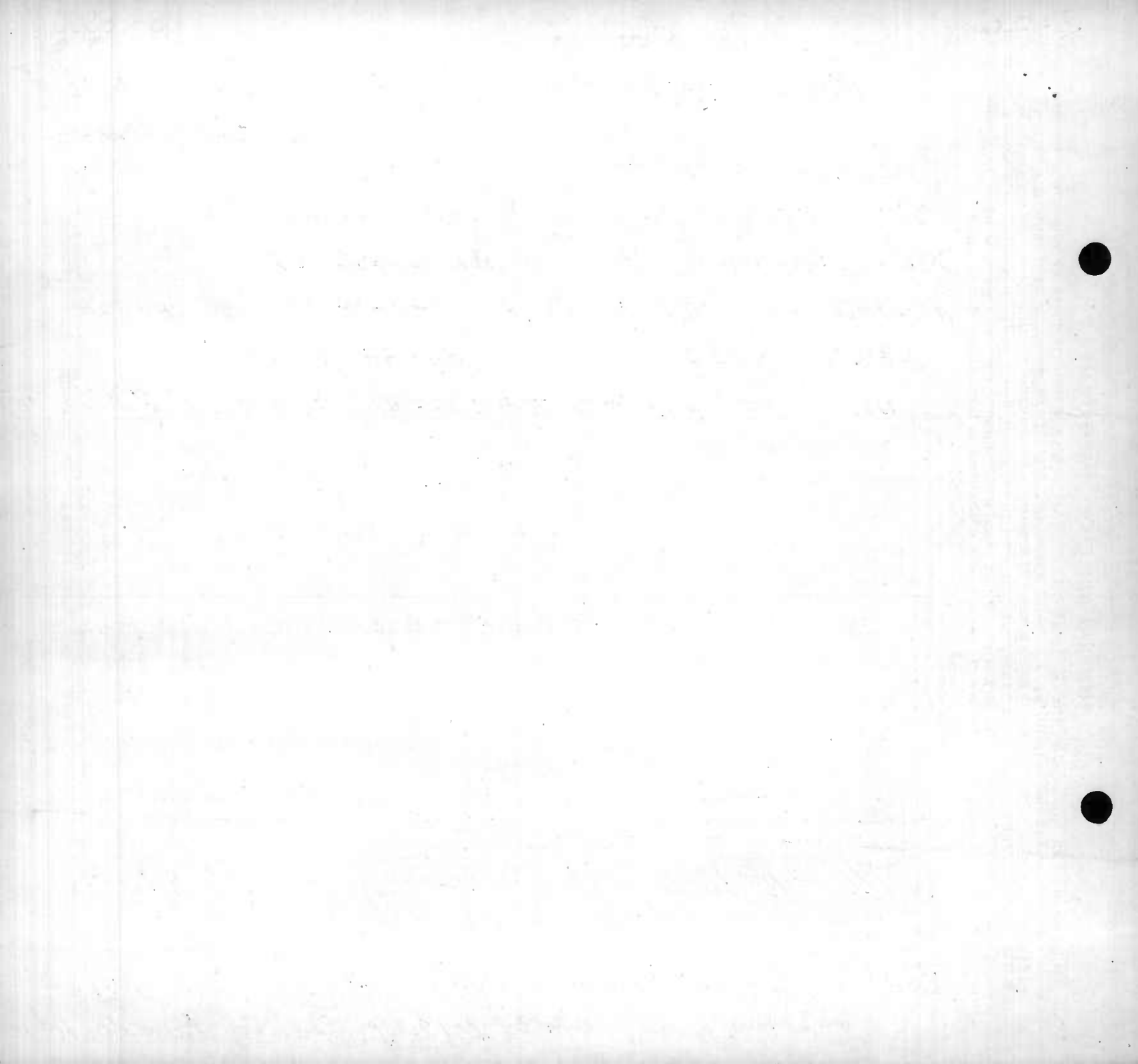
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 68- 8300 CERTIFICATE OF DEATH

REG. NO. **68- 8300**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MILTON WEBER REESOR</b>		2. DATE AND HOUR OF DEATH <b>AUG. 11, 1968 3:30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b>		C. CITY OR TOWN <b>DUNDALK</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 HOUSE IN PINES</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>5837 BELAIR ROAD</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>MALE</b>		6. RACE <b>CAUCASIAN</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HYDRO. ELECTRIC</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>METER INSPTR.</b>		8. DATE OF BIRTH <b>SEPT. 30, 1880</b>	
11. BIRTHPLACE (State or foreign country) <b>CANADA</b>		9. AGE (in years last birthday) <b>87</b>		12. CITIZEN OF WHAT COUNTRY? <b>CANADA</b>	
13. FATHER'S NAME <b>LEWIS REESOR</b>		14. MOTHER'S MAIDEN NAME <b>SARAH WEBER</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>212-56-7541</b>		17. INFORMANT <b>CONSTANCE R. O'TOOLE</b>		ADDRESS <b>AS IN #4 ABOVE</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>410.9 I</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Myocardial Infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>71 years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>420.1 II</b>		(B) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>1 year</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Arteriosclerotic Cardiovascular Disease</b>		(C) <b>Arteriosclerotic Cardiovascular Disease</b>		<b>1 year</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 26 1968</b> to <b>August 11 1968</b> , that (I) (we) last saw the deceased alive on <b>August 7 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Walter B. Bradley</b>		DEGREE		23B. DATE SIGNED <b>8/14/68</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. MEDICAL DIRECTOR'S NAME (Type)	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/14/1968</b>		24C. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>	
24D. LOCATION (City, town, or county) <b>HAGERSTOWN, MD.</b>		24E. STATE <b>MD.</b>		24F. ZIP CODE <b>21740</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 14 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Walter B. Bradley, Dundalk, Md.</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>68- 8301</b>	
BIRTH NO. <b>68-14344</b>		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>Baby Boy Lee</b>		2. DATE AND HOUR OF DEATH <b>11:45 p.m. 7/22/68</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>34 Bon Secours Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>18-03</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>1030 Booth Street 21223</b>	
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/22/68</b>
		9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <b>2</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Young Lee</b>		14. MOTHER'S MAIDEN NAME <b>BARBARA Williams</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war & dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>HOSPITAL/Bo</b> ADDRESS
18. <b>770.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <b>Placenta previa</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Premature &amp; male infant (300 gm)</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Natural Steurom + hydrocephalus + hydropericranium</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A): <b>761.5 II</b>	
19A. DATE OF OPERATION <b>7/23/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>7/22/68</b> 19 to 19 that (I) (we) lost saw the deceased alive on <b>7/22</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>[Signature]</b>		23B. DATE SIGNED <b>7/23/68</b>	23C. PHYSICIAN'S NAME (Type) <b>Dr. [Signature]</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/12/68</b>	24C. NAME OF CEMETERY or CREMATORY <b>St. Peter's Cem</b>
24D. LOCATION (City, town, or county) (State) <b>Baeto, MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 14 1968</b>	
25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR <b>Thomson &amp; Kenney Inc</b> ADDRESS <b>Baeto</b>	

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## FUNERAL DIRECTOR: IMPORTANT

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V-452		68- 8302		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 8302	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>JOSEPHINE E. VELENOSKY</b>			
2. DATE AND HOUR OF DEATH <b>8-12-68</b>				2. DATE AND HOUR OF DEATH <b>9-00 A. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland #21224</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>742 North Kenwood Avenue #21205</b>							
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/20/00</b>	
9. AGE (In years lost birthday) <b>67</b>		10. UNDER 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Furniture Coverings</b>			
13. FATHER'S NAME <b>Karl Velenousky</b>				14. MOTHER'S MAIDEN NAME <b>Mary Svehla</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>212-09-0450 A</b>		17. INFORMANT <b>BCH Records: 4940 Eastern Avenue</b> <b>Baltimore, Maryland #21224</b>	
18. <b>436.91x250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>C.V.A.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Generalized arteriosclerosis</b> <b>Diabetes mellitus</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>331X II</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) <b>YES</b>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>7-11-68</b>			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>7-11-68</b> 19 <b>68</b> to <b>8-12</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8-12</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Boon Vanasin</b>				23B. DATE SIGNED <b>Aug 12, 68</b>			
23C. PHYSICIAN'S NAME (Type) <b>DR. BOON VANASIN, M.D.</b> <b>BOON VANASIN</b>				23D. ADDRESS <b>4940 Eastern Avenue, Balto., Md.</b> <b>Baltimore City Hosp #21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burned</b>				24B. DATE <b>8-16-68</b>			
24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 14 1968</b>				25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>			
25C. FUNERAL DIRECTOR <b>Philip J. Cook</b>				25D. ADDRESS <b>1211 Chase after</b>			

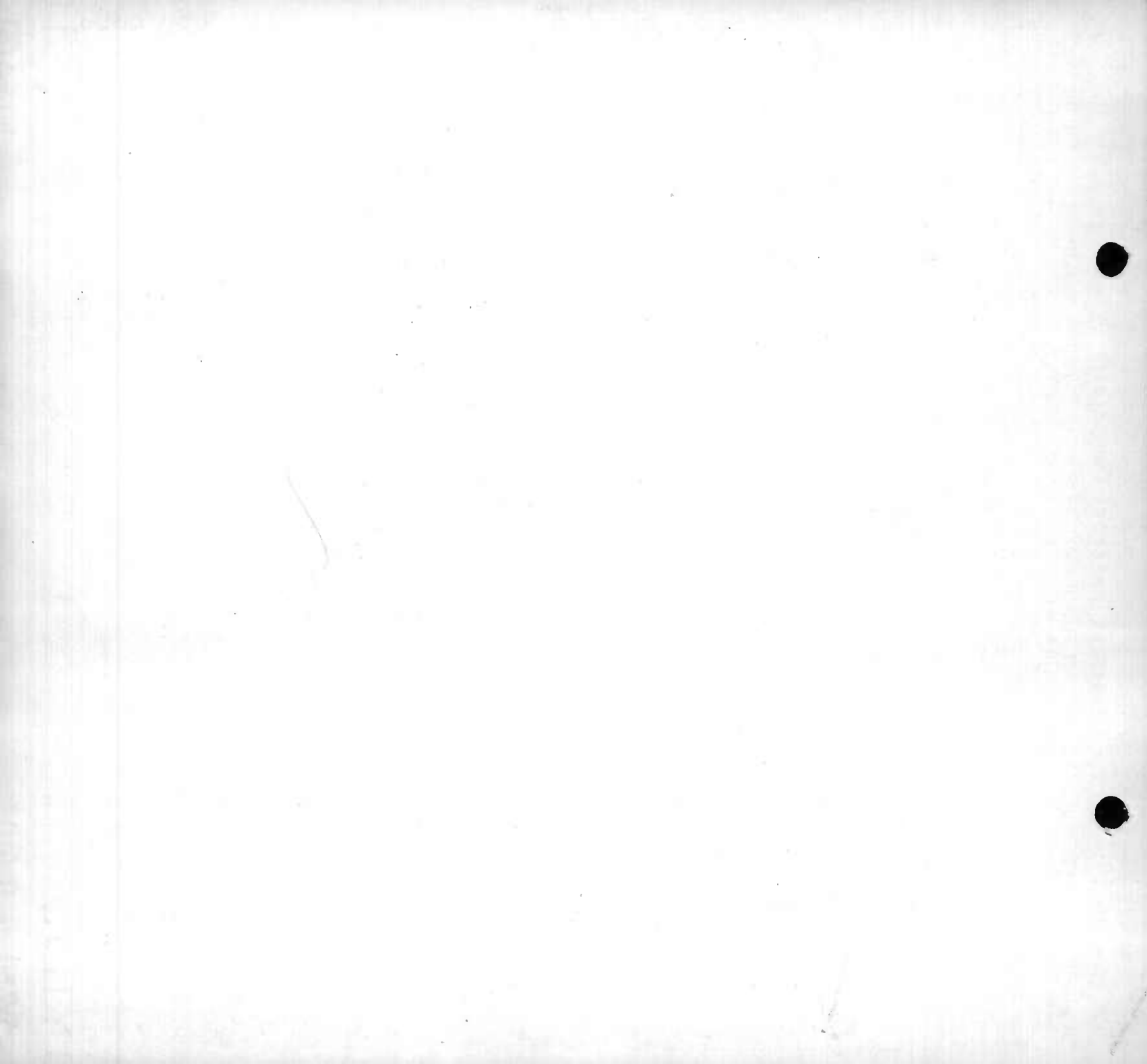


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# BALTIMORE CITY HEALTH DEPARTMENT 68- 8303 CERTIFICATE OF DEATH

REG. NO. 68- 8303

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BROOKS FLORENCE</b>		2. DATE AND HOUR OF DEATH <b>8-10-1968</b> <b>5:20 PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>15-03</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL OF MD</b> <b>46</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>		8. DATE OF BIRTH <b>April 6, 1900</b> 68 9. AGE (In years last birthday) <b>68</b>	
11. BIRTHPLACE (State or foreign country) <b>HALIFAX CO. VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William Edmondson</b>		14. MOTHER'S MAIDEN NAME <b>JEANETTE Baldwin</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220305819</b>		17. INFORMANT ADDRESS <b>IRENE WEST 2108 WESTWOOD</b>	
18. CAUSE OF DEATH <b>162.1 I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>163X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>(A) IMMEDIATE CAUSE</b> <b>Disseminated malignancy</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Liver</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Pleura bones</b> <b>(2) Superimposed Bacterial Infection</b> <b>Probably Pneumonia</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>2:45 PM 8-10-1968</b> to <b>5:20 8-10-1968</b> , that (1) (we) last saw the deceased alive on <b>8-10-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. Satya</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Dr. SATYA</b>				23D. ADDRESS <b>LUTHERAN HOSPITAL OF MD. 730 Ashburton St. BALTO. MD 21216</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>10/14/68</b>		24B. DATE <b>10/14/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT AUBURN CEM.</b>	
24D. LOCATION (City, town, or county) <b>WEST PORT MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 14 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fairman</b>		25C. FUNERAL DIRECTOR ADDRESS <b>DONALD E. GLOVER 1761 N. PATTERSON PK.</b>			



47-99-07 LE

## FUNERAL DIRECTOR: IMPORTANT

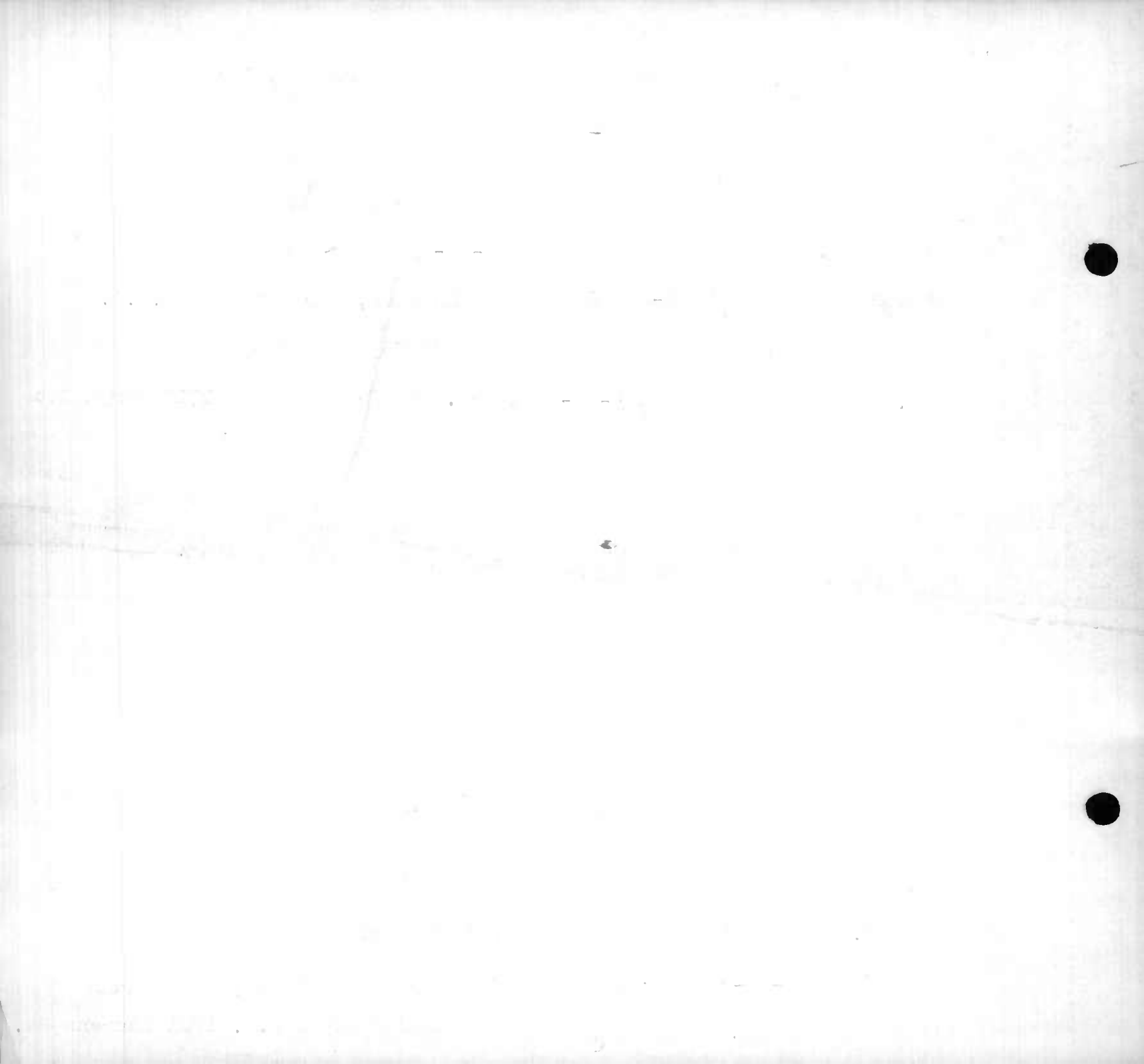
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-8304	
BIRTH NO. 4-453 68-8304					
1. NAME OF DECEASED (Type or Print) Helen HOLLAND		2. DATE AND HOUR OF DEATH 8/12/68 4:15 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 31 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE		6. RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		8. DATE OF BIRTH 12-26-1904	
13. FATHER'S NAME ALFRED HAMMOND		14. MOTHER'S MAIDEN NAME Addie HAMMOND		9. AGE (In years lost birthday) 63	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-54-1615 T		11. BIRTHPLACE (State or foreign country) MARYLAND, Frederick	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
				17. INFORMANT ADDRESS RECORDS: BALTIMORE CITY HOSPITALS 4940 EASTERN AVE., BALTO., MD. 21224	
18. 4369 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Aspiration pneumonia 1 week DUE TO, OR AS A CONSEQUENCE OF: (B) Old CVA 2 yrs DUE TO, OR AS A CONSEQUENCE OF: (C) Dehydration + Poor Nutrition Chronic		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 331X II		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/10/68 to 8/12/68, that (I) (we) last saw the deceased alive on 8/12/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bruce J. Nothmann M.D.		23B. DATE SIGNED 8/12/68		23C. PHYSICIAN'S NAME (Type) BRUCE J. NOTHMANN, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-16-68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F.H. 1701 Laurens St.	
24D. LOCATION Baltimore, Maryland		24E. LOCATION (City, town, or county) (State)			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

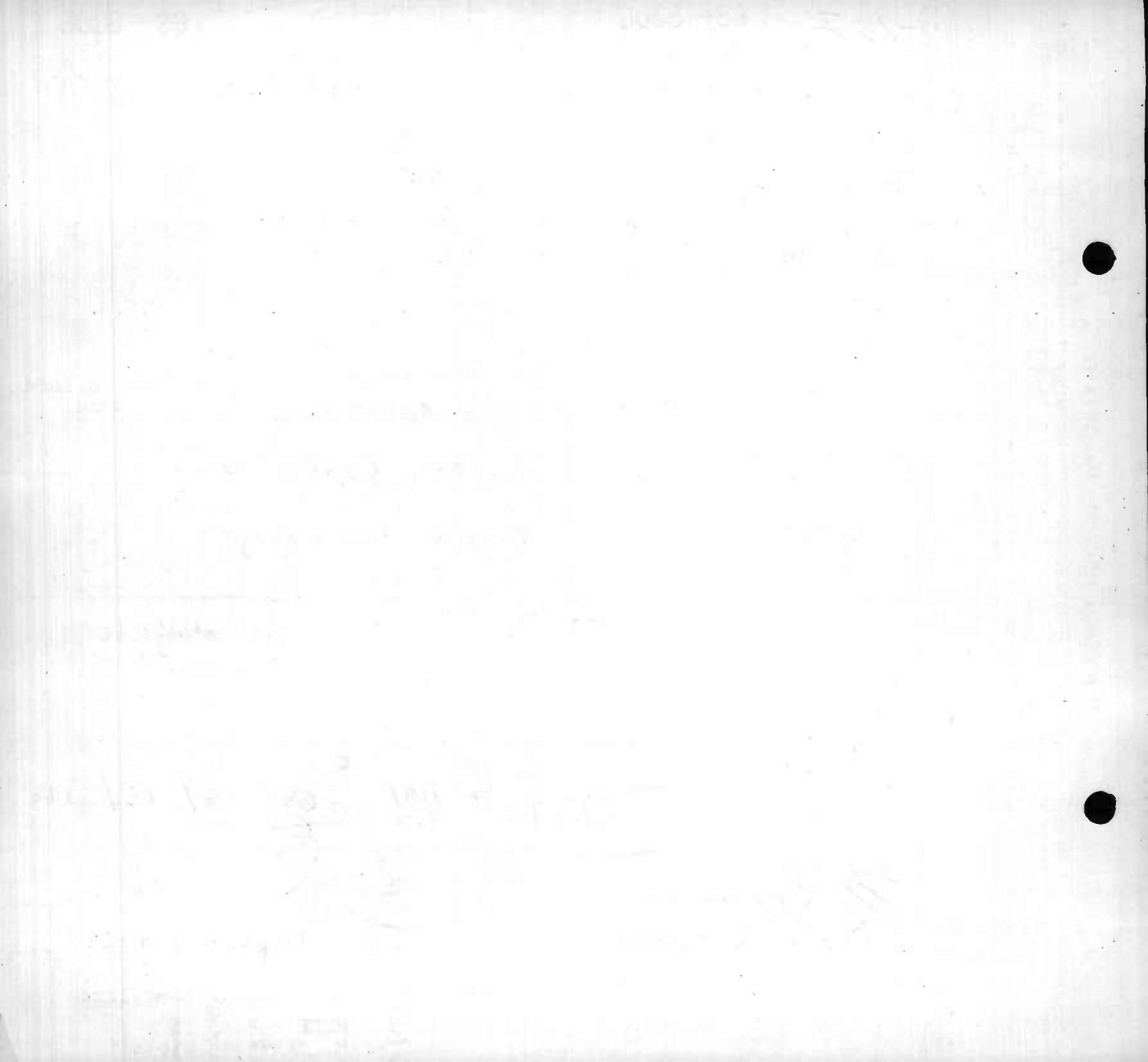
BIRTH NO. <u>7-622</u>		BALTIMORE CITY HEALTH DEPARTMENT		68-8305	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CHARLES FERGUSON		August 11, 1968	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  42 SINIA HOSPITAL		A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2721 Beryl Avenue			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8-24-25	9. AGE (In years last birthday) 42	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Beth-Steel		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME OSCAR FERGUSON		14. MOTHER'S MAIDEN NAME LILLIE MAE BRISCOE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 215-22-2271		17. INFORMANT Mrs. Lillian Ferguson 2721 Beryl Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 1B. 412.31 CAUSE OF DEATH (A) Complete heart block DUE TO (B) Coronary disease DUE TO (C) Myocardial infarct		INTERVAL BETWEEN ONSET AND DEATH 1 day 1 week 10 weeks			
19. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-16-67 to 8-11-68, that (I) (we) last saw the deceased alive on 8-11-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Harold Nichols		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-13-68	
23C. PHYSICIAN'S NAME (Type) J. HAROLD NICHOLS		23D. ADDRESS M.D. 7 South Lake			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-15-68		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 14 1968			
25B. NAME OF REGISTRAR R. L. E. Smith		25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F.H. 1701 Laurens St.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-162 68-8306		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-8306	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)			
		Devereaux, Margaret DEVEREAUX 8/13/68			
2. DATE AND HOUR OF DEATH		8/13/68 3:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
Johns Hopkins 33			Maryland		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			Baltimore		9-08
			E. STREET AND NUMBER		
			2106 Harford Rd.		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7/3/98	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		At Home		Pittsburgh Penn.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Hugh Duff			Catherine Harper		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		217 54 8475		2106 Harford Road	
18. 458.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Rep Cardiac arrest		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Massive hemorrhage DUE TO, OR AS A CONSEQUENCE OF:		
			(C)		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			Achalsia, pneumonia, gastrostomy tube		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/19/1968 to 8/13/1968, that (I) (we) last saw the deceased alive on 8/13/1968 and that (my) (our) applan death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
M. Lippman				8/13/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Marc Lippman		Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/15/68		Baltimore National Cemetery Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 14 1968		Robert E. Johnson		HENRY SANDER & SONS INC. BALTIMORE, MARYLAND 21213	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68- 8307	
J-250 68- 8307				REG. NO.	
BIRTH NO.				68- 8307	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Mercedes M. Jackson			August 12, 1968		M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 1307 Decatur St.			Maryland		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			1307 Decatur St.		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	April 25, 1908	60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Machine Operator		McCormick & Co.		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Joseph Nelson			Catherine Herbert		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			212-09-6285		Roland Jackson 1307 Decatur St.
18. 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Coronary Occlusion Immediate		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Hypertensive cardio vascular disease 2 yrs		
			(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from May 22, 1962 19 to August 12, 1968 19 that (I) (we) last saw the deceased alive on August 5, 1968 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Harry Deibe M.D.				August 13, 1968	
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Harry Deibe M.D.			1226 S. Hanover Street Balto. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8/16/68		New Cathedral Cemetery Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 14 1968		Robert E. Jenkins		Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue	



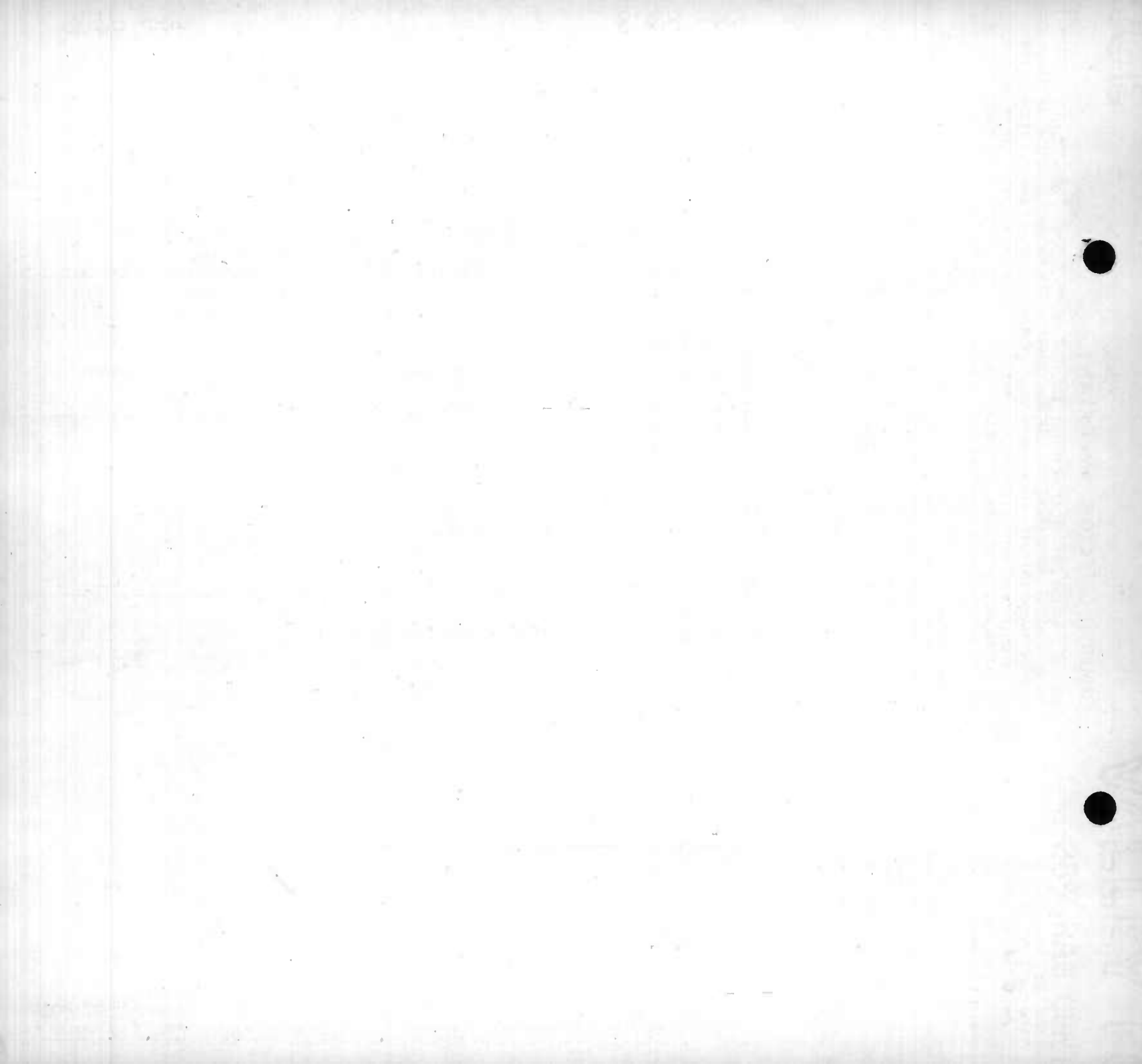
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8308

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 8308

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Ryncewicz, Stella (Stani Slawa)</u>		2. DATE AND HOUR OF DEATH <u>Aug 12, 1968</u> <u>10:45 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>72 SINAI HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? <u>YES</u> E. STREET AND NUMBER <u>221 S. CHESTER STREET</u>			
5. SEX <u>F</u>	6. RACE <u>CAU.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 8, 1897</u>	9. AGE (In years lost birthday) <u>71 YRS.</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>POLAND</u>	
13. FATHER'S NAME <u>RUSZKOWSKI</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-46-2413</u>		17. INFORMANT <u>EDWARD RYNCEWICZ</u> ADDRESS <u>6700 DANVILLE AVENUE</u>	
18. <u>440.91-250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION (s).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Pulmonary Infection</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerotic vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>430.0 II Diabetes mellitus</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>Aug. 12</u> 19 <u>68</u> to <u>Aug 12</u> 19 <u>68</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>Aug 12</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>M. Horenstein M.D.</u>		23B. DATE SIGNED <u>8/12/68</u>		23C. PHYSICIAN'S NAME (Type) <u>M. HORENSTEIN M.D.</u>	
23D. ADDRESS <u>72 Sinai Hospital</u>		24. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
24B. DATE <u>8-16-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>HOLY ROSARY CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>DUNDALK MARYLAND</u>	
25A. DATE RECD. HEALTH DEPT. <u>AUG 14 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Farkas</u>		25C. FUNERAL DIRECTOR <u>JOHN M. WEBER &amp; SONS INC.</u> ADDRESS <u>401 S. CHESTER</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# CERTIFICATE AMENDED

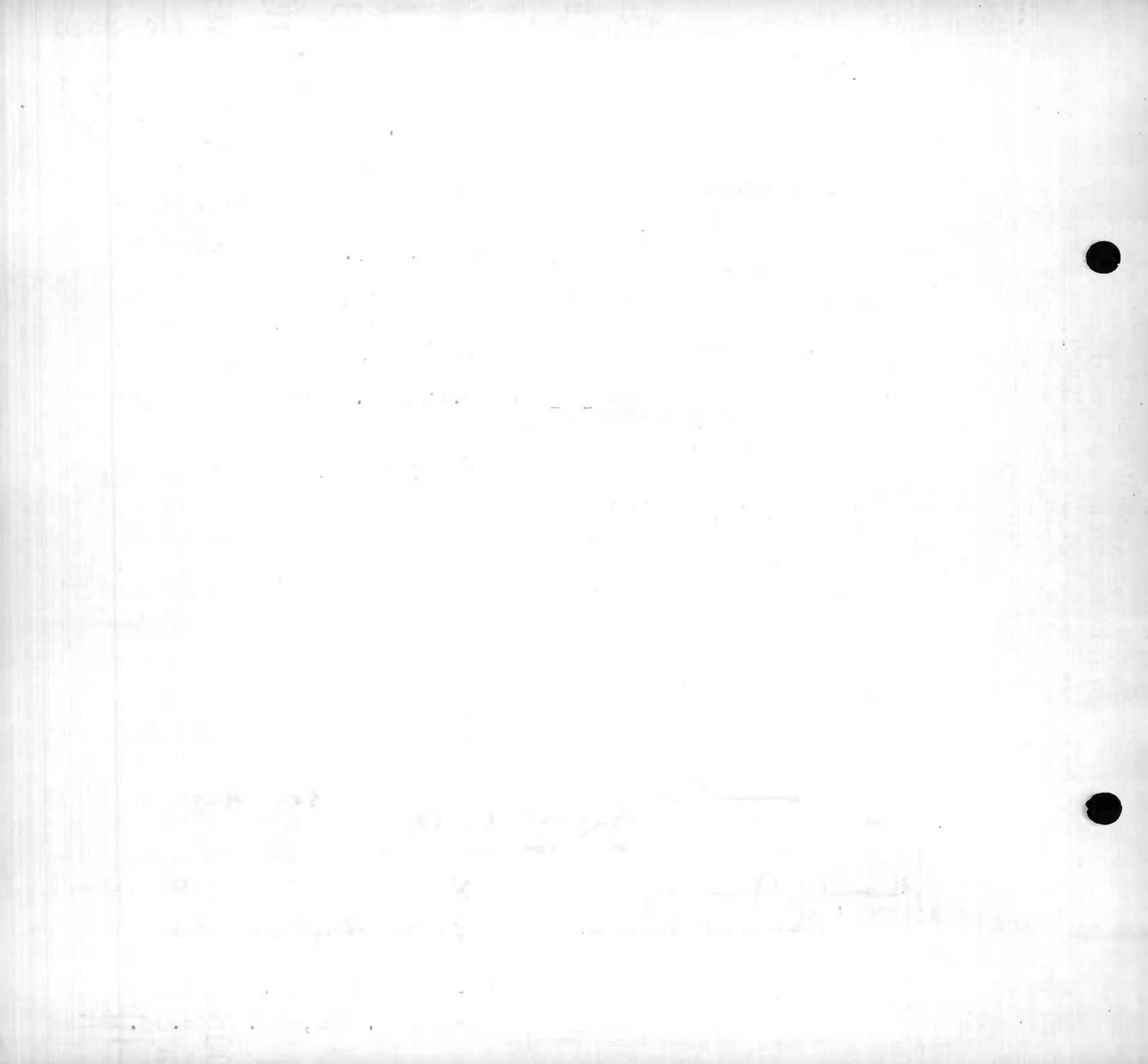
68- 8309		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 68- 8309	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Betka-Thomas John		8.13.68 6:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
Franklin Sq. Hospital		Maryland Baltimore		Baltimore 53-00	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
M W				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Retired		Mercantile Safe Deposit & Trust		12/4/1894 73	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years, last birthday)	
John Betka		Agnes Petakowski		75	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes 11/3/10 to 4/27/35		212-09-4203		Mrs. Tillie Betka 3479 McShane Way Balto, 22,	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		Ac leukemia			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
204.3 II		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8.5.68 19 to 8.13.68 19, that (I) (we) last saw the deceased alive on 8.13.68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
M. A. FZAL		8.13.68			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		Franklin Sq. Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8/17/68		St. Stanislaus Cemetery	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
Dundalk Ave-Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 14 1968		Robert E. Finkbeiner		George A. Weber 705 South Ann Street	

Cert. Delayed 8429 (BCHD) for Thomas J. Betka born December 4, 1892

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
68- 8310 CERTIFICATE OF DEATH					REG. NO. 68- 8310				
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) <u>Miles Franklin Alban</u>					2. DATE AND HOUR OF DEATH <u>8-14-68</u> <u>6A</u> M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>27-06</u>				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>00 6300 Marietta Avenue</u>					C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER <u>6300 Marietta Avenue</u>				
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 27, 1907.</u>		9. AGE (In years last birthday) <u>61</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steamfitter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Union Local # 438</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>George Alban</u>					14. MOTHER'S MAIDEN NAME <u>Margaret I Rose</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>213 -10-9204</u>		17. INFORMANT <u>Mrs. Hilda L. Alban</u>			ADDRESS <u>(Same)</u>	
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Cancer of lung</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. <u>163X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cancer of lung</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) ( <del>was</del> <u>not</u> hospital) attended the deceased from <u>1958</u> to <u>Aug. 14</u> 19 <u>68</u> , that (I) ( <del>was</del> <u>not</u> ) last saw the deceased alive on <u>August 1, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>was</del> <u>not</u> ) (did) ( <del>not</del> <u>do</u> ) view the body after death.									
23A. SIGNATURE <u>Ronald Jandorf</u> DEGREE					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>8-14-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Ronald Jandorf</u> DEGREE					23D. ADDRESS <u>6077 Harford Rd</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/17/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Moreland Memorial Park</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 14 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>			25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21211</u>			ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8311 CERTIFICATE OF DEATH

REG. NO. 68- 8311

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Mary A. Molloy</b>		2. DATE AND HOUR OF DEATH <b>August 12, 1968.</b> <b>11:30 PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Edgewood Nursing Home</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>27-02</b>	
				C. CITY OR TOWN <b>Baltimore</b>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>2823 Montebello Terrace</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 12, 1903.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired--Dress Designer</b>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <b>64</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Madigan</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Murnane</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-24-3051-J-1</b>		17. INFORMANT <b>Mrs. Patricia Watts, 613 Highwood Dr. #12</b>	
18. <b>438.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Insufficiency -</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>General Arteriosclerosis -</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>334X II</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION <b>8-12-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) <b>8-12-68</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-11-1968</b> to <b>8-12-1968</b> , that (I) (we) last saw the deceased alive on <b>8-11-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Anthony F. Carozza</b> DEGREE				23B. DATE SIGNED <b>8-13-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Anthony F. Carozza M.D.</b> DEGREE				23D. ADDRESS <b>5217 YORK Rd. Bto Md 21212</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/16/68.</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 14 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Sullivan</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>	

Cerebral Inflammation

General Atrophic Process

8-13-68

8-11-68 2:15 PM

8-12-68

Robert F. Gifford

X

8-15-68

2012 York Rd Bldg 212

B-650

68-8312 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-8312

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Mary ARLENE

BROWN

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☒

Month

Day

Year

Hour

August 13, 1968

1:10 A. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1524 E. 33rd Street

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

August 13, 1968

1:25 A. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

female

7. RACE

white

8. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Jan. 6, 1947.

10. AGE (In years  
last birthday)

21

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1524 E. 33rd Street

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Roger C. Brown

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Stenographer

14B. KIND OF BUSINESS OR INDUSTRY

Oil Company

15. MOTHER'S MAIDEN NAME

Gladys G. Carr

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, not unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

215-48-11462

18. INFORMANT

ADDRESS

Mr. Roger C. Brown, 3826 Monterey Rd.

19.

E966X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Stabwound of Chest

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

E982X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

home

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1524 E. 33rd Street

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

8/13/68

1:10 A.

m.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

subj. stabbed in chest

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/13/68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8/16/68.

24C. NAME OF CEMETERY or CREMATORY

Gardens of Faith Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT

AUG 14 1968

25B. NAME OF REGISTRAR

Robert E. Taylor, Jr.

25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

N873.1

WALLACE

POINTER

Robert E. Jones

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
KRAUS, George Carl		8-13-68		3:50 A M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland		Maryland Baltimore Co 53-00		
C. CITY OR TOWN		D. INSIDE CITY LIMITS?		
Baltimore,		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER				
1930 Summit Ave				
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6-14-15	33
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Denist Associate		Dental		Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
George Kraus		Rebecca King		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
YES 8/18/43 to 12/29/46		213-20-6121		VAH, Balto., Md. 3900 Loch Raven Blvd 21218
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				2 years
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchogenic Carcinoma with Metastasis to brain				
(B) DUE TO, OR AS A CONSEQUENCE OF:				
(C) DUE TO, OR AS A CONSEQUENCE OF:				
18.2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
				NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (X) (this hospital) attended the deceased from August 8, 19 68 to August 13, 19 68, that (X) (we) last saw the deceased alive on August 13, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
Susan H. Mather, M.D.				August 13, 1968
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
SUSAN H. MATHER, M.D.		3900 Loch Raven Boulevard Baltimore, Maryland 21218		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)
Burial	Aug. 15, '68	Baltimore National		Baltimore Maryland
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS		
AUG 14 1968	Robert E. Fisher, Jr.	John T. Stansbury, Sr. 6411 Windsor Mill Rd		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased, prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8314	
BIRTH NO.		68- 8314		F.	
1. NAME OF DECEASED (Type or Print)		SARAH (TRAVIES) TRAYIERS		2. DATE AND HOUR OF DEATH 8/10/68 11:19 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE 31303		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
JOHNS HOPKINS HOSP. 33		E. STREET AND NUMBER 1114 BRENTWOOD AVE.			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/13/93	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Thomas Travies		14. MOTHER'S MAIDEN NAME Sarah	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT CLARA TRAYIERS 907 N. FREMONT AVE.	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SEPTICEMIA (B) TRANSITIONAL CA OF BLADDER DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
18. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). DIABETES MELLITUS		19A. DATE OF OPERATION 2/18/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 8/9/68 19 to 8/10 1968, that (I) last saw the deceased alive on 8/10 1968 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death.					
23A. SIGNATURE Michael D. Lutz, M.D.		23B. DATE SIGNED 8/10/68			
23C. PHYSICIAN'S NAME (Type) MICHAEL D. LUTZ, M.D.		23D. ADDRESS DEPT. OF MED. JHH			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/68		24C. NAME OF CEMETERY OR CREMATORY Mt. CALVARY CEM.	
24D. LOCATION ANNE ARUNDEL COUNTY		24E. DATE REC'D BY HEALTH DEPT. AUG 15 1968		24F. NAME OF REGISTRAR Robert E. Johnson	
24G. FUNERAL DIRECTOR WM C MARCH		24H. ADDRESS 938 E NORTH AVE			

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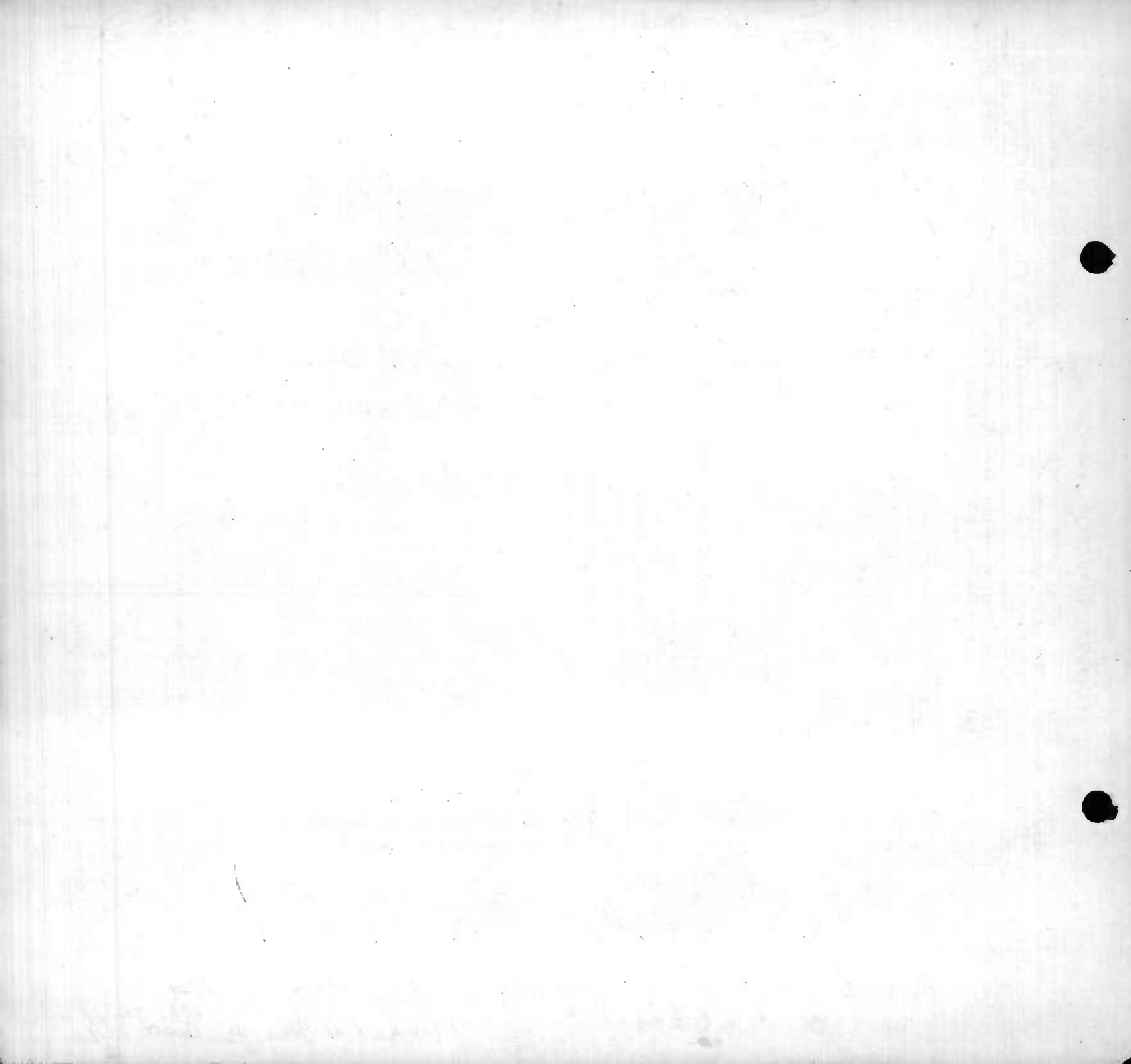
10/12/50

10/12/50

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>D-140</b>		68- 8315		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>68- 8315</b>	
1. NAME OF DECEASED (Type or Print) <b>Hattie L. Duva!!</b>				2. DATE AND HOUR OF DEATH <b>8/13/68</b> <b>1:15</b> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Mercy Hospital, Baltimore</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <b>422 E. 21st St.</b>			
5. SEX <b>F.</b>	6. RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/17/67</b>	9. AGE (In years last birthday) <b>13 Months</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Joseph Wardell</b>				14. MOTHER'S MAIDEN NAME <b>INA DUVALL</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>INA DUVALL 422 E. 21st ST</b>			
18. <b>320.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH 1. meningitis 2. peritonitis 3. septicemia 2 days (?) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Biliary atresia, biliary cirrhosis with ascites</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
19. <b>340.3 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>August 13</b> 19 <b>68</b> to <b>Aug 13</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Aug 13</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>S.K. Shin</b>				23B. DATE SIGNED <b>8/14/68</b>		23C. PHYSICIAN'S NAME (Type) <b>S.K. SHIN</b>	
23D. ADDRESS <b>Mercy Hosp., Inc.</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-17-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT CALVARY Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>A.A. Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 15 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fink</b>		25C. FUNERAL DIRECTOR <b>Marshall W. Jones, Jr.</b>		ADDRESS <b>1735 Haywood Ave. Balt. Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8316 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 68- 8316

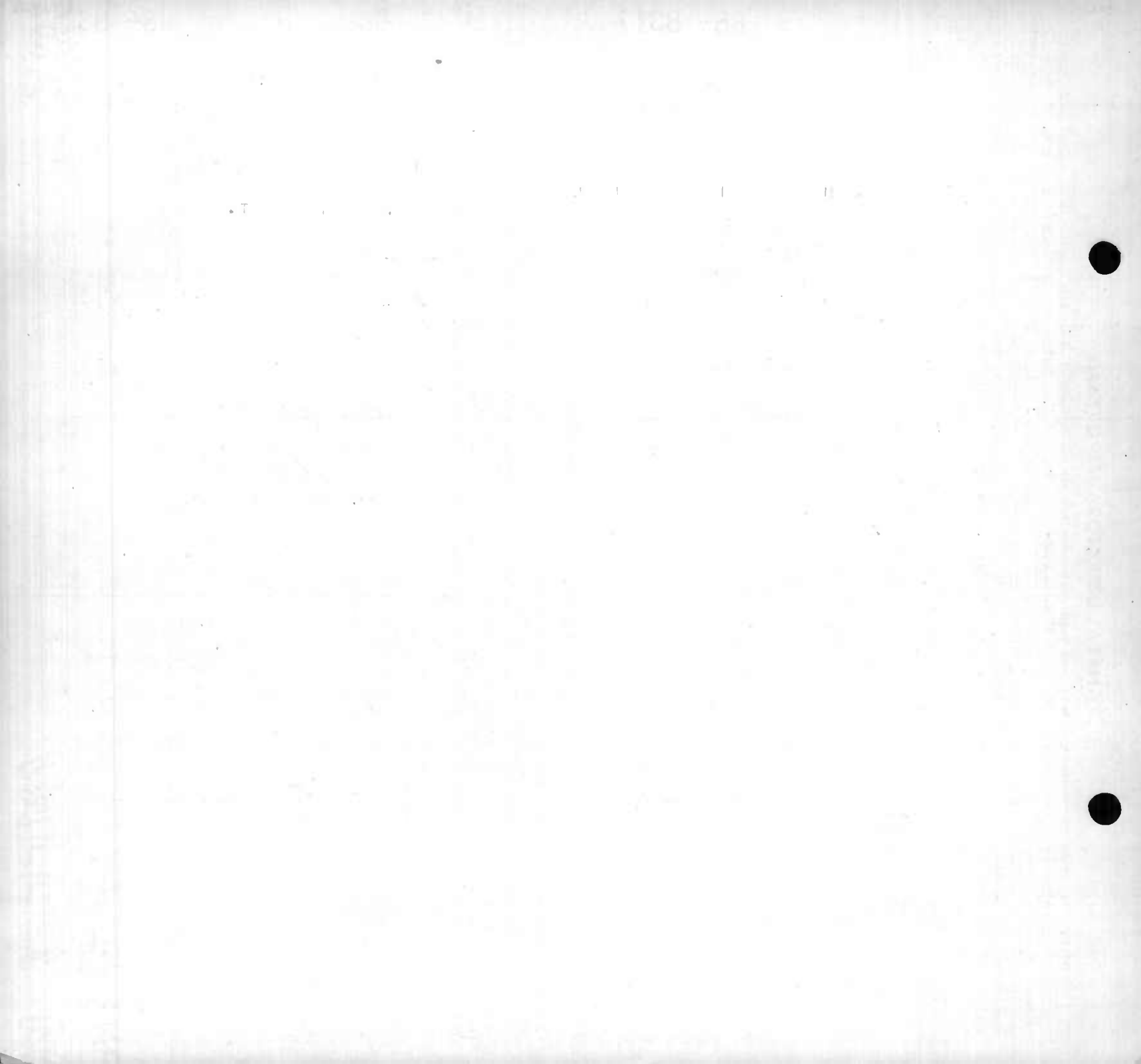
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>EARTIE JACOBS</b>		2. DATE AND HOUR OF DEATH <b>Aug. 6, 1968</b> <b>10<sup>30</sup></b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>8-07</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>John Hopkins Hosp.</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>1338 N. Washington St.</b>		
5. SEX <b>Female</b>	6. RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 16<sup>th</sup> 1906</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>Henry Jacobs</b>		
14. MOTHER'S MAIDEN NAME <b>Ollie Jacobs</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Elbert Jacobs</b>		
ADDRESS			<b>3015 Cranston Ave.</b>		
18. <b>410.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarct</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>A.C.V.D.</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarct</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>A.C.V.D.</b> (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 mins</b>			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>420.1 II</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 29, 1968</b> to <b>July 29, 1968</b> ; that (I) (we) last saw the deceased alive on <b>July 29, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>A.C. Burwell, M.D.</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>A.C. Burwell, M.D.</b>				23D. ADDRESS <b>1520 E. Monument W.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-12-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT. Calvary Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Brooklyn, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>Aug 15 1968</b>			
25B. NAME OF REGISTRAR <b>John E. ...</b>		25C. FUNERAL DIRECTOR <b>Phray O. Wilson</b>			
ADDRESS <b>1000 Brambley Ave.</b>					



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8317 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8317	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)	
				CHARLES JONES	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH 8-12-68 9:05 PM	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY MARYLAND	
33 THE JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1228 E. MADISON ST.	
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-10-85	9. AGE (In years lost birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Return Minister			Georgia		USA
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Edith Williams
					ADDRESS
18. 486X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia & Respiratory failure and Dehydration (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days
493X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 10 1968 to August 12 1968, that (I) (we) lost saw the deceased alive on August 12 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Douglas T. Fearon M.D.				23B. DATE SIGNED Aug. 12, 1968	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
DOUGLAS T. FEARON M.D.				The Johns Hopkins Hosp. Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		8-17-68		Mt Auburn Cmt	
24D. LOCATION (City, town, or county)		24E. FUNERAL DIRECTOR			
Baltimore		Elroy Wilson 1000/Prinity/kr			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. ADDRESS	
AUG 15 1968		Ruth E. Taylor		1000/Prinity/kr	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>68- 8318</u>	
BIRTH NO. <u>68- 8318</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Edwards Joseph Calvin</u>		2. DATE AND HOUR OF DEATH <u>8. 11. 68</u>   <u>1:48 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>36 Franklin Square hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Baltimore</u> B. COUNTY <u>Maryland</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>252 N. Arlington Ave 41223</u>			
5. SEX <u>Male</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>?</u>	8. DATE OF BIRTH <u>5. 18. 11</u>	9. AGE (In years lost birthday) <u>57</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>?</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
13. FATHER'S NAME <u>Richard Edwards</u>		14. MOTHER'S MAIDEN NAME <u>Hannie Wallace</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Sumner Souder Seal</u>	
18. <u>15-4.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>&lt; Terminal CA Rectum</u> DUE TO		(B) <u>&lt; Renal failure</u> DUE TO	
		(C) <u>&lt; Pneumonia</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>154X II</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6. 17. 68</u> to <u>8. 11. 1968</u> , that (I) (we) last saw the deceased alive on <u>8. 10. 68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M. Afzal</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8. 11. 68</u>	
23C. PHYSICIAN'S NAME (Type) <u>M. AFZAL</u>		23D. ADDRESS <u>Franklin Sq. Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-15-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>McLachlan Cmt</u>	
24D. LOCATION (City, town, or county) (State) <u>Brooklyn Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 15 1968</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR <u>Elroy O. Wilson</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8319 CERTIFICATE OF DEATH

REG. NO. 68- 8319

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Cora Miller</u>		2. DATE AND HOUR OF DEATH <u>8-12-68</u> <u>4</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Balt.</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1024 Bennett Place</u>					
5. SEX <u>Female</u>	6. RACE <u>negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/90</u>	9. AGE (In years last birthday) <u>78</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Miller</u>		14. MOTHER'S MAIDEN NAME <u>Addline</u>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Daughter</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Acute MI</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1-2 da.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF:			
(C) —					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>420.1 II</u>					
19A. DATE OF OPERATION <u>8-16-68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>7-8-68</u> 19 <u>68</u> to <u>8-12-68</u> 19 <u>68</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>8-12</u> 19 <u>68</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ruth Ann Przybylski M.D.</u>				23B. DATE SIGNED <u>8-12-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Ruth Ann Przybylski M.D.</u>				23D. ADDRESS <u>University Hospital</u>	
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-16-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Midland Art</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 15 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Eloy O. Miller</u>	
ADDRESS					



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>FRANKLIN BROCK</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>August 10, 1968</b> Hour: <b>9:00</b> - <b>10:00 P.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>1706 N. Washington St.</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>August 11, 1968</b> Hour: <b>1:50 P.</b>	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>5-06</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
9. DATE OF BIRTH <b>March 9-1936</b> 32		10. AGE (In years last birthday) <b>32</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salad</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Salad</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>217-30-4086</b>	
18. INFORMANT <b>Luan Brock</b>		ADDRESS <b>1706 N. Washington St.</b>	
19. <b>5-71-81</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Fatty Alteration of Liver</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>5-8-68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>8/12/68</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-15-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Antietam</b>		24D. LOCATION (City, town, or county) (State) <b>Antietam MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 15 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>	
25C. FUNERAL DIRECTOR <b>Eloy Wilson</b>		ADDRESS <b>10043</b>	

WALSH & COMPANY  
VALLEY VIEW

Wm. L. Walsh

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 8321

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

FRANK

GLOVER

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

August

11,

1968

9:30 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1908 E. Lanvale Street

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

August

11,

1968

9:30 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

male

7. RACE

negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS

YES ☒ NO ☐

9. DATE OF BIRTH

July 1 1901

10. AGE (In years  
lost birthday)

67

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1908 E. Lanvale Street

11. BIRTH PLACE (State or foreign country)

Smithfield Va

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Walter Glover

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Ida Wells

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

217-01-8862

18. INFORMANT

Gloria Glover Lane

ADDRESS

19.

162.1

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenic, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

Carcinoma of Lung

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S

NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/12/68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8-16-68

24C. NAME OF CEMETERY or CREMATORY

Antebellum Court

24D. LOCATION (City, town, or county)

Antebellum Md

25A. DATE REC'D BY HEALTH DEPT.

AUG 15 1968

25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

Roy Wilson

ADDRESS

1000 Beauty



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8322

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>TOM DURANT</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 13 68 10:25 p M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) OR INSTITUTION <b>1817 W. Saratoga St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 13 1968 10:25 p M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Colored</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>Sept. 18, 1918</b>		10. AGE (In years lost birthday) <b>49</b>	
11. BIRTHPLACE (State or foreign country) <b>Lynchburg S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stock Clerk</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>CatsPaw Rubber Co.</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes W.W 2</b>		17. SOCIAL SECURITY NO. <b>18-01</b>	
15. FATHER'S NAME <b>Lucius Durant</b>		15. MOTHER'S MAIDEN NAME <b>Rose</b>	
18. INFORMANT <b>Dorothy Durant</b>		ADDRESS <b>817 W. Saratoga St.</b>	
19. <b>398X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Rheumatic heart disease</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Rheumatic heart disease</b>	
20. <b>416X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Chronic pyelonephritis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Notural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Shipped</b>		24B. DATE <b>8/16/1968</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Lynchburg Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Lynchburg S.C.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 15 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>	
25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>		ADDRESS <b>3179 Schroeder St.</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 8323 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 8323

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Honor Juile DeAngelis</i>		2. DATE AND HOUR OF DEATH <i>8/12/68 12:40 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balto</i> <i>53-00</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland Hospital</i> <i>38</i>			C. CITY OR TOWN <i>Essex</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <i>107 Eastern Blvd.</i>		
5. SEX <i>M</i>	6. RACE <i>Cauc.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/20/08</i>	9. AGE (In years last birthday) <i>60</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Photographer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Photography</i>		11. BIRTHPLACE (State or foreign country) <i>France</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Paul DeAngelis</i>		14. MOTHER'S MAIDEN NAME <i>Beja ???</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-07-9839</i>		17. INFORMANT <i>Rose DeAngelis (wife) same as above</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>531.9 + 120.3 X</i> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Septicemia</i>		<i>4 days</i>	
		(B) <i>Peritonitis + Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF:		<i>8-11 Days</i>	
		(C) <i>Pyloric Ulcer</i>		<i>20+ Days</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>540.0 II</i>		<i>Multiple Myeloma</i>		<i>?</i>	
19A. DATE OF OPERATION <i>8/1/68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Pyloric Ulcer</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7/28</i> 19 <i>68</i> to <i>8/12</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>8/12</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Lloyd B. Mandel MD</i>				23B. DATE SIGNED <i>8/12/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Lloyd B. Mandel MD</i>				23D. ADDRESS <i>University Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-15-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>St. Gertrude's Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Colonia, New Jersey</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 15 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Connelly Funeral Home - 300 More</i>			

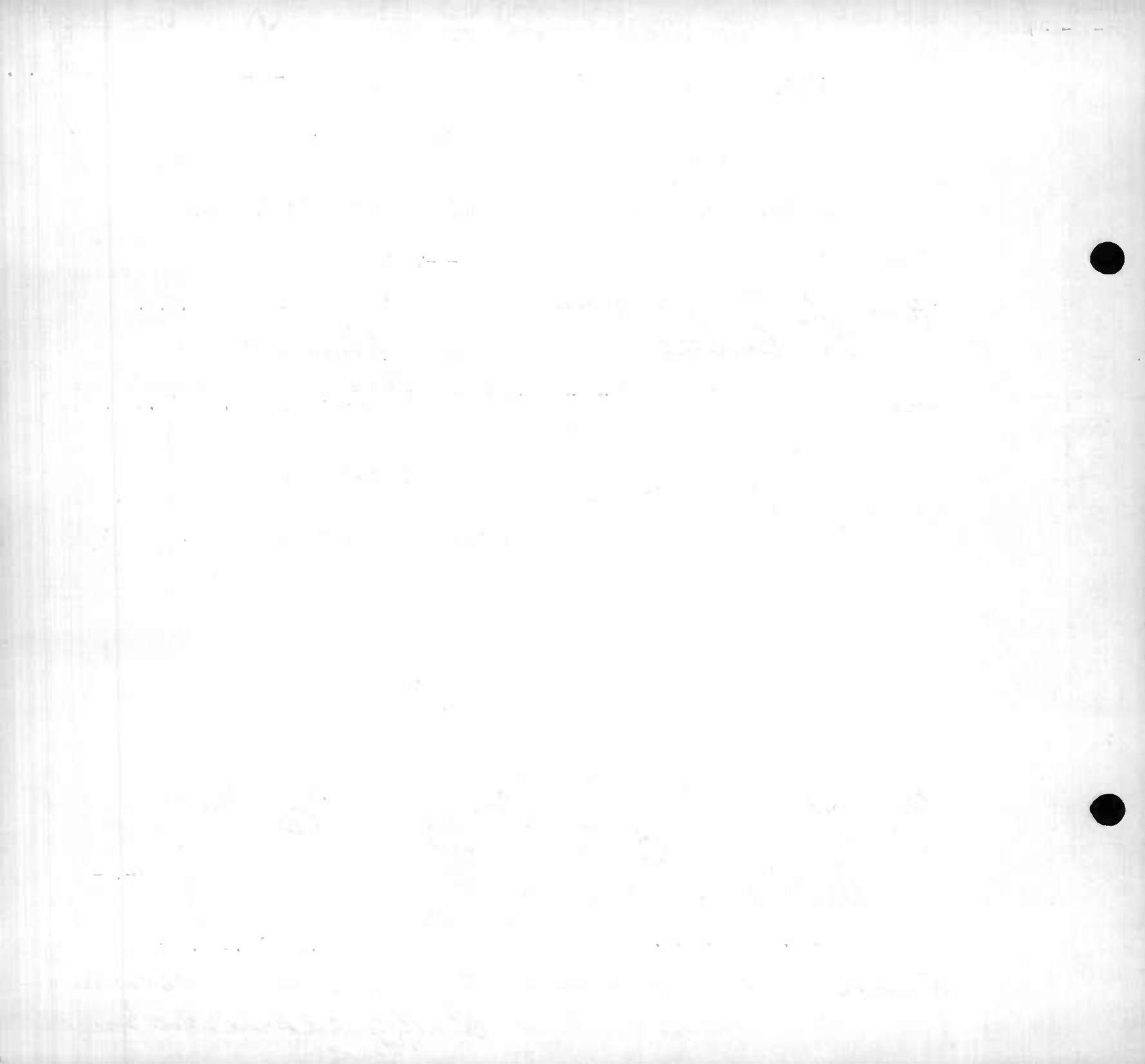


39-13-42 LB 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		ALPHA, JENNINGS		2. DATE AND HOUR OF DEATH 12 Aug 8-12-68		5 35:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224						A. STATE MARYLAND B. COUNTY BALTIMORE			
C. CITY OR TOWN						D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 124 ALCOCK ROAD 21221 005									
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-5-1900		9. AGE (In years lost birthday) 68	
10A. USUAL OCCUPATION (Give kind of work done during most of working life (even if retired)) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) KENTUCKY		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME PETE Barrett				14. MOTHER'S MAIDEN NAME JANE Johnson					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 239-03-7843-A		17. INFORMANT BALTIMORE CITY HOSPITALS 4940 EASTERN AVE., BALTO., MD. 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 410.9 I CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction 3 min						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 min			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) Atherosclerotic heart disease 8 yrs (C) _____									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II Pt. on respirator for 3 wks.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from Aug 1 1968 to Aug 12 1968, that (1) (we) last saw the deceased alive on Aug 12 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE David J. Riley M.D.						23B. DATE SIGNED Aug 12, 1968			
23C. PHYSICIAN'S NAME (Type) DAVID J. RILEY, M.D.						23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE., BALTO., MD. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 8-14-68		24C. NAME OF CEMETERY or CREMATORY Greenhill Cemetery		24D. LOCATION (City, town, or county) (State) Ashville - North Carolina			
25A. DATE RECEIVED BY HEALTH DEPT. Aug 15 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Connelly Funeral Home - 300 Wace		ADDRESS			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

REG. NO. 68- 8325

VS 150-REV. 1/1/6B

CHURCH WINE AND SPIRITS  
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8-10-46

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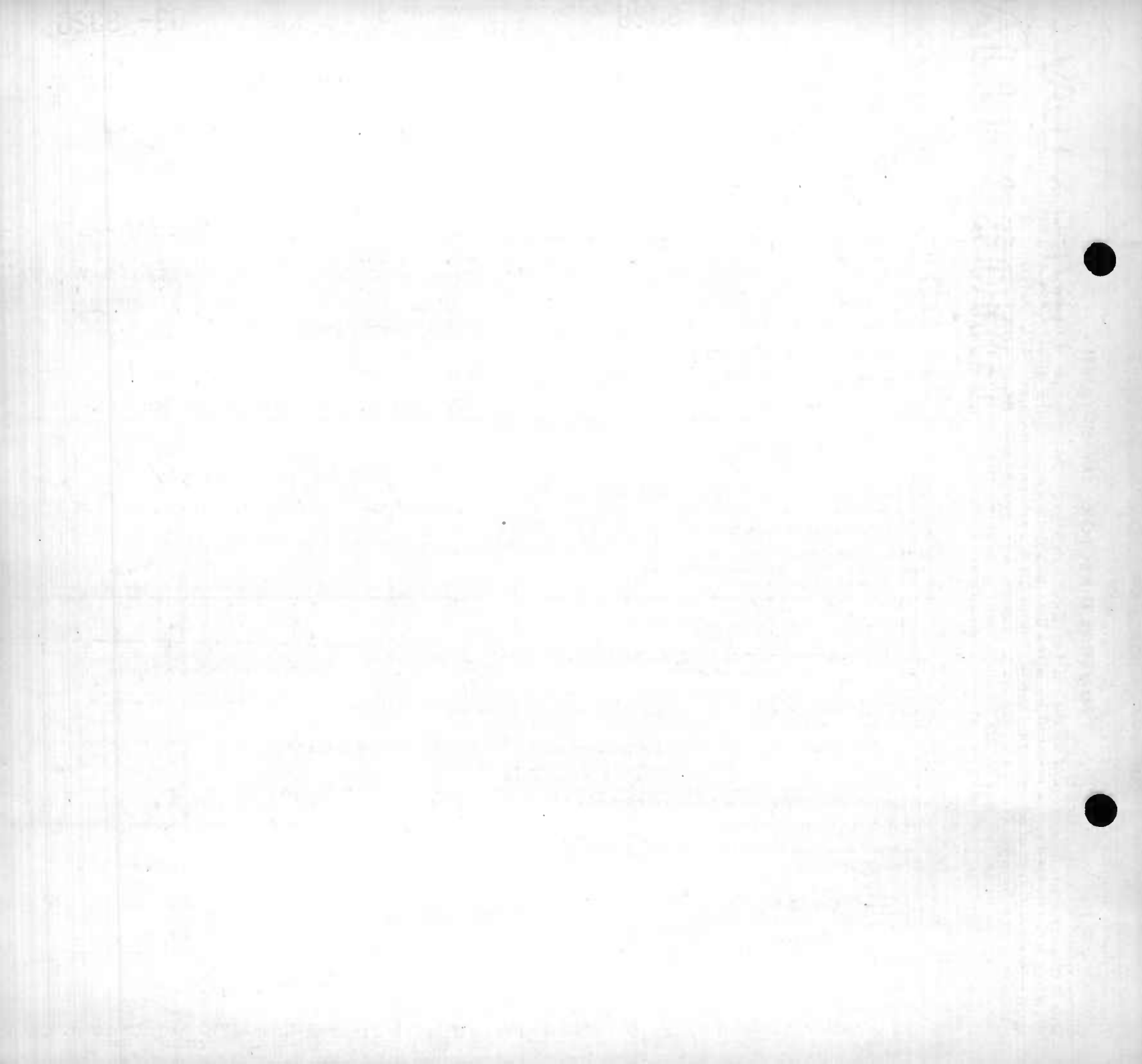
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8326	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Zoa Mary Lovell		August 14, 1968 1:45 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 5403 Creston Ave.			A. STATE Maryland B. COUNTY 27-34		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 5403 Creston Ave.		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 29, 1877	9. AGE (In years lost birthday) 90	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Francis J. Little			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Frances O. Lovell 5403 Creston Ave.		
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
189.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinoma, generalized Primary site unknown</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
189.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Feb 1968 to 8/14 1968, that (I) (we) last saw the deceased alive on 8/13 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George H. Beck M.D.			23B. DATE SIGNED 8/14/68		
23C. PHYSICIAN'S NAME (Type) George H. Beck, M.D.			23D. ADDRESS 6012 Harford Road		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/17/67	24C. NAME OF CEMETERY or CREMATORY Oak Field Cemetery	24D. LOCATION (City, town, or county) (State) Crooksville, Ohio		
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1968	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR Ullrich Funeral Home		ADDRESS 4210 Belair Road. Baltimore, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8327	
BIRTH NO.		68- 8327		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Reightler, Lula. Ola.</b>		2. DATE AND HOUR OF DEATH <b>August 10, 1968 9 05 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Union Memorial Hospital.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland, Baltimore.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> E. STREET AND NUMBER <b>612 W 36th Street.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 5, 1878</b>	9. AGE (In years last birthday) <b>89</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <b>Maryland.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>215 46 8859.</b>		17. INFORMANT <b>John F. Reightler</b> <b>deceased's daughter.</b> ADDRESS <b>5420 FRANKLIN AVE</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute MI.</b> (B) <b>ASCVD.</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>pneumonia &amp; pulmonary edema.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> <b>greater 10 yrs.</b> <b>unknown.</b>	
19A. DATE OF OPERATION <b>None.</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>No</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>No</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>No</b>		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>Aug 9 1968</b> to <b>Aug 10 1968</b> , that (1) (we) last saw the deceased alive on <b>Aug 10 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Brian Block M.D.</b>				23B. DATE SIGNED <b>10 Aug 68.</b>	
23C. PHYSICIAN'S NAME (Type) <b>Brian Block.</b>		23D. ADDRESS <b>Union Memorial Hospital.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-14-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>WOODLAWN</b>	
24D. LOCATION (City, town, or county) (State) <b>WOODLAWN, BALT, Co. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 15 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>BURGEE FUNERAL HOME</b> <b>William R. Kluber</b>			

Union Memorial Hospital

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Green Block

Union Memorial Hospital

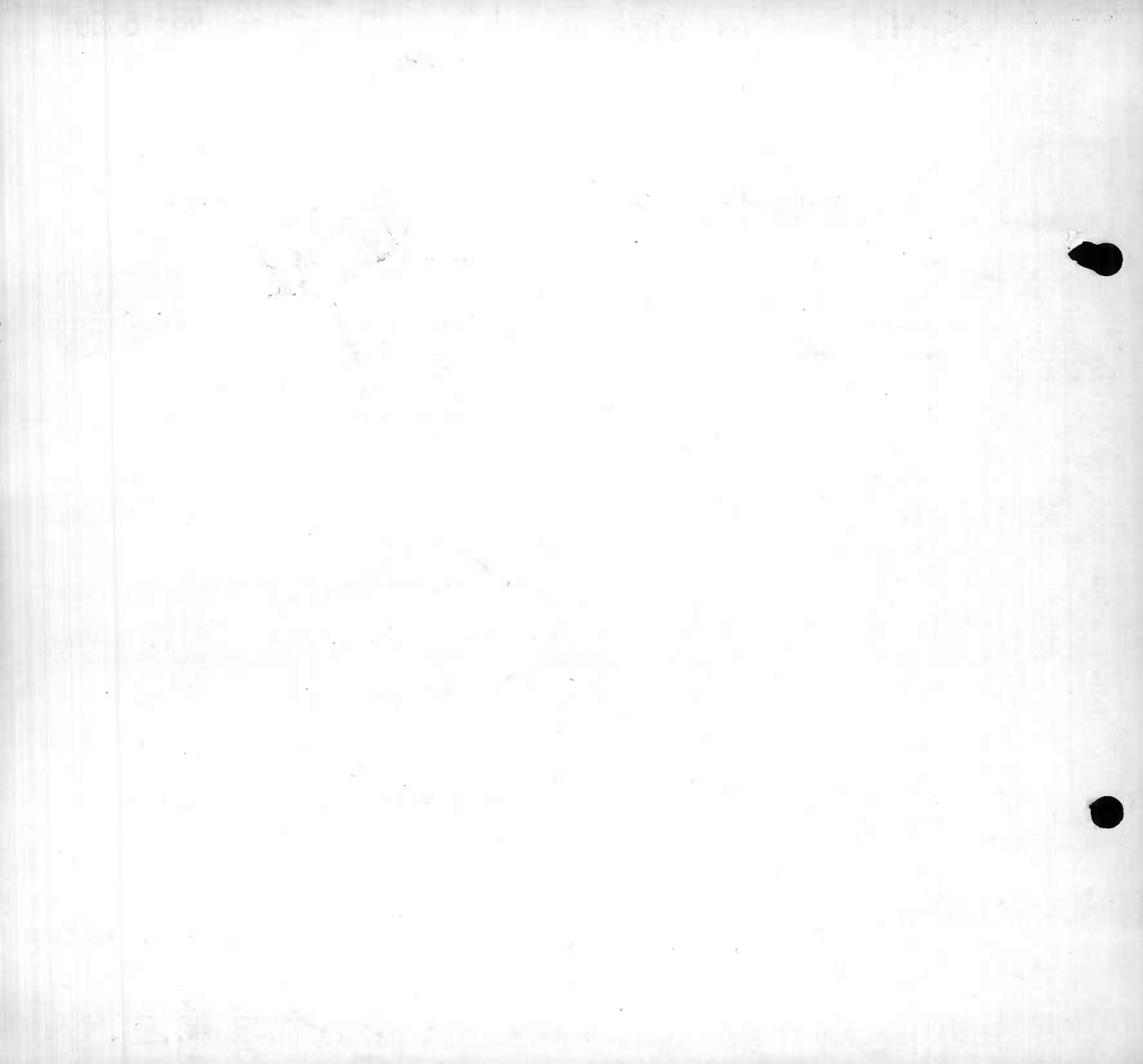
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P-230		68- 8328		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 8328	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) PICKETT, MARY VIRGINIA				AUGUST 10, 1968   6:20 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
40 ST. AGNES HOSPITAL		CATON & WILKENS AVES.		MARYLAND 21043		HOWARD CO. 63-00	
BALTIMORE, MD. 21229				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				ELLICOTT CITY		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER				208 MAIN ST.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	10. Under 24 Hrs. Days	10. Under 24 Hrs. Hours
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	10-10-89	78			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE				MARYLAND		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JEREMIAH KELLEY				MARY (BURRELL) KELLEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
		220446412		AVES. BALTO MD. 21229 ST. AGNES RECORDS- WILKENS & CATON			
18. 174X I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		Generalized carcinomatosis			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF		A primary lesion of breast			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)					
170X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (X) (this hospital) attended the deceased from AUGUST 2 19 68 to AUGUST 10 19 68, that (X) (we) last saw the deceased alive on AUGUST 10 19 68 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Charles J. Lancelotta, M.D.				8/11/68			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
CHARLES J LANCELOTTA				ST AGNES HOSP. BALTO MD 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/13/1968		St. John's Cemetery		Ellicott City, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 15 1968		Robert E. Fairbanks		Easton Funeral Home		Catonsville, Md.	

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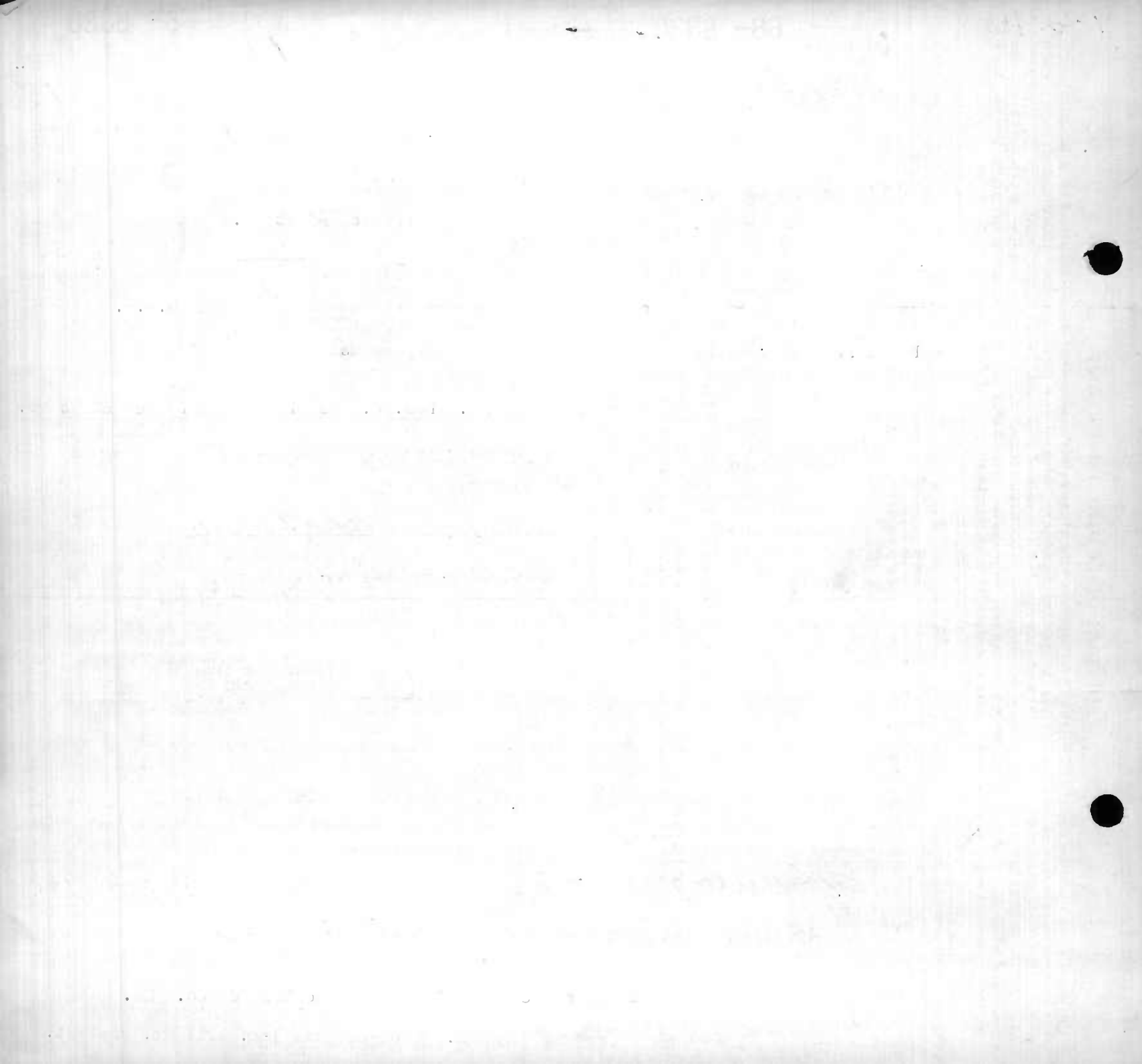
BIRTH NO.		68- 8329		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 8329	
1. NAME OF DECEASED (Type or Print) <b>HALLIE COLVIN</b>				2. DATE AND HOUR OF DEATH <b>8/10/68</b> <b>1040 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>7-02</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> <b>314940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND #21224</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>FEMALE</b> 6. RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>9-21-18</b>		9. AGE (In years last birthday) <b>49</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>School</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>George Abel</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Linton</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>161-34-8159</b>				17. INFORMANT ADDRESS <b>BCH RECORDS: 4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND # 21224</b>			
18. <b>486X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIAC ARREST</b> (B) <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>CHRONIC KYPHOTIC LUNG DISEASE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 MIN.</b>							
19. <b>493X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>RHEUMATOID ARTHRITIS</b>							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>July 6th</b> 19 <b>68</b> to <b>August 10th</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>August 10th</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>V. Valdmann MD</b>				23B. DATE SIGNED <b>8/10/68</b>		23C. PHYSICIAN'S NAME (Type) <b>VIDVUD VALDMANIS, M. D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/14/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Crest Lawn Gardens</b>		24D. LOCATION (City, town, or county) (State) <b>Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 15 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>Robert C. Altenburg Funeral Home, Inc.</b>		25D. ADDRESS <b>6009 Harford Rd.-Balto., Md. 21214</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 8330
BIRTH NO. <u>68-15110</u>		68- 8330 -		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Baby Bay Voskuhl</u>			2. DATE AND HOUR OF DEATH <u>8-9-68</u>   <u>7<sup>30</sup></u> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore Co.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy Hospital</u>			C. CITY OR TOWN <u>Owings Mills</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>108 Enchanted Hills Dr.</u>		
5. SEX <u>M.</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-8-68</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Thomas Charles Voskuhl</u>			14. MOTHER'S MAIDEN NAME <u>Nancy August</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mr. Thos. C. Voskuhl</u>		
			ADDRESS <u>108 Enchanted Hills Dr.</u>		
18. <u>770.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>RESPIRATORY ARREST</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASPHYXIA NEONATORUM</u>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>COMPLETE PLACENTAL SEPARATION</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>761.0 II</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>NO</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug. 8</u> 19 <u>68</u> to <u>Aug 8</u> 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Arturo A. Santos</u>			23B. DATE SIGNED <u>Aug 9, 1968</u>		
23C. PHYSICIAN'S NAME (Type) <u>ARTURO A. SANTOS, M.D.</u>			23D. ADDRESS <u>MERCY HOSP.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/12/68</u>		24C. NAME of CEMETERY or CREMATORY <u>Glen Haven Memorial Park</u>	
				24D. LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 15 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks, Inc. 1217 St. Paul St.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burrs; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

## 68- 8331 CERTIFICATE OF DEATH

REG. NO. 7

68- 8331

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

**BOSCHELLI, Joe Joseph G.**

2. DATE AND HOUR OF DEATH

**Aug 13 1968**

**6:15 A M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

**The Johns Hopkins Hospital**

**33**

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  
A. STATE B. COUNTY

**Pennsylvania**

C. CITY OR TOWN

**New Cumberland**

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

**303 Haldeman Ave.**

5. SEX

**Male**

6. RACE

**White**

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

**3/19/00**

9. AGE (In years last birthday)

**68**

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Barber**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Italy**

12. CITIZEN OF WHAT COUNTRY?

**U.S.A.**

13. FATHER'S NAME

**Vincent**

**Boschelli**

14. MOTHER'S MAIDEN NAME

**Marie**

**Intreri**

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

**Unk**

16. SOCIAL SECURITY NO.

**180-26-6688A**

17. INFORMANT

ADDRESS

**Virginia Boschelli 303 Haldeman Ave.**

**162.1 I**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

**adenocarcinoma of lung**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**6 mos.**

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

**163X II**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

**None**

19A. DATE OF OPERATION

**None**

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

**None**

20A. AUTOPSY? (Yes or No)

**No**

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

**None**

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At Work ☐

Not White At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~the~~ (this hospital) attended the deceased from **8-3** 19 **68** to **8-13** 19 **68**, that ~~we~~ (we) last saw the deceased alive on **2:30 am 8-12** 19 **68** and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~we~~ (we) (did) (did not) view the body after death.

23A. SIGNATURE

**William W. Lukemeyer MD**

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

**8/13/68**

23C. PHYSICIAN'S NAME (Type)

**William W. Lukemeyer, M.D.**

23D. ADDRESS

**1620 McElderry St 10A3**

**BALTIMORE MARYLAND**

24A. BURIAL CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**8/16/68**

24C. NAME OF CEMETERY or CREMATORY

**Holy Cross Cemetery**

24D. LOCATION

**Harrisburg, Pa.**

(City, town, or county)

(State)

25A. DATE RECEIVED BY HEALTH DEPT.

**AUG 16 1968**

25B. NAME OF REGISTRAR

**Robert E. Fisher, Jr.**

25C. FUNERAL DIRECTOR

**Wm. Cook-Brooks Funeral Home 1217 St. Paul St**

ADDRESS

admission number filed 6/25/88

None

No

None

None

8-13 8-13

8-13 8-13 8-13

Wm W. Suberbaugh MD

1630 M. E. 24th St. N. W.

X

8/13/88

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
**68- 8332 CERTIFICATE OF DEATH**

REG. NO. **68- 8332**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ELSNER, JOSEPH FERDINAND</b>		2. DATE AND HOUR OF DEATH <b>Aug. 13, 68 8 50 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>University of Maryland, Hosp Bmtg, Md. 21201</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS <b>28</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4721 DARTFORD AVE. 21229</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-23-04</b>	9. AGE (In years lost birthday) <b>63</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assembly Supervisor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CANADAY</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>JOHN ELSNER</b>		14. MOTHER'S MAIDEN NAME <b>Ellie MARTIN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-05-5585</b>		17. INFORMANT <b>Elizabeth K. Elsner Balto., Md. 21229</b>	
18. <b>441.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Ruptured Abdominal Aortic Aneurysm</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF (B) DUE TO, OR AS A CONSEQUENCE OF (C) _____		
19. <b>457X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Renal Failure</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>Aug 12-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>abdo. Aneurysm</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M. H. Gonzalez</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>M. H. Gonzalez</b>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-16-68</b>		24C. NAME of CEMETERY or CREMATORY <b>Lorraine Park Cemetery</b>	
24D. LOCATION <b>5608 Dogwood Rd., Balto., Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>AUG 15 1968</b>			
25A. NAME OF REGISTRAR <b>Robert E. Talley</b>		25B. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

## 8333 CERTIFICATE OF DEATH

REG. NO.

68- 8333

BIRTH NO. Harre de Grace, Md.

1. NAME OF DECEASED  
(Type or Print)

TERESA L. BANDY

2. DATE AND HOUR OF DEATH

1:25 AM 8/11/68

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

SOUTH BALTIMORE GENERAL HOSPITAL

43

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

HARVARD DE GRACE

C. CITY OR TOWN

CHURCHVILLE

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

GENERAL DELIVERY

62-00

5. SEX

FEMALE CAUCASIAN

6. RACE

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

7-19-68

9. AGE (In years lost birthday)

If Under 1 Yr. Months: Days

0 23

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

INFANT

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

HARVARD DE GRACE MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JAMES BANDY

14. MOTHER'S MAIDEN NAME

PATRICIA PORTER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

R.T. ROSENSTEEL M.D.

ADDRESS

S.A.G. Hos 12

18. 786X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

ASPIRATION PNEUMONIA

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

LESS THAN 15 MIN

(B) DUE TO, OR AS A CONSEQUENCE OF:

HEMATEMESIS

27 hr

(C) DUE TO, OR AS A CONSEQUENCE OF:

CONVULSIVE DISORDER

23 DAYS

MEDICAL CERTIFICATION

791X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~the~~ (this hospital) attended the deceased from JULY 29 19 68 to AUGUST 11 19 68, that (I) we last saw the deceased alive on AUGUST 11 19 68 and that in my our opinion death occurred on the date and hour and from the causes stated above. (I) We (did) (~~did not~~) view the body after death.

23A. SIGNATURE

Robert J. Rosensteel M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

8/11/68

23C. PHYSICIAN'S NAME (Type)

ROBERT J. ROSENSTEEL, M.D.

23D. ADDRESS

SOUTH BALTIMORE GENERAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 13, 68

24C. NAME OF CEMETERY or CREMATORY

Bel Air Memorial Gardens

24D. LOCATION

(City, town, or county)

Bel Air, Harford Co. Maryland

(State)

25A. DATE RECEIVED BY HEALTH DEPT.

AUG 15 1968

25B. NAME OF REGISTRAR

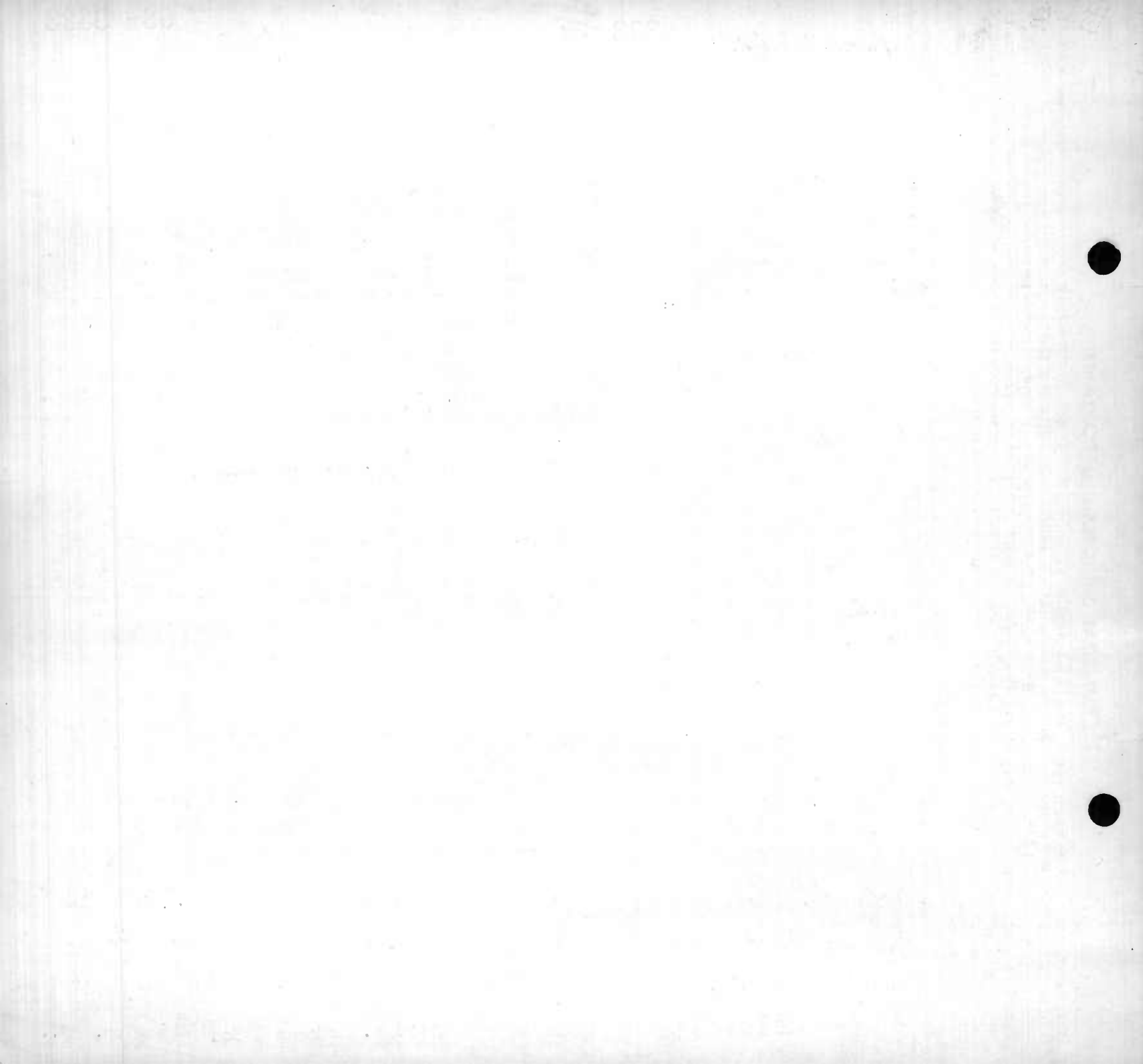
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Howard K. McComas & Son

ADDRESS

Abingdon, Md..



R-200

68- 8334 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8334

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

OPLE

RICH

2. DATE  
OF  
DEATHKnown ☐ Estimated ☒

Month

Day

Year

Hour

August 9, 1968

4:30 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1613 St. Paul St.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

August 12, 1968

8:45 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

male

7. RACE

white

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Aug. 30, 1911

10. AGE (In years  
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1613 St. Paul St.

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Mark Rich

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Shoe Cobbler

14B. KIND OF BUSINESS OR INDUSTRY

Shoe Repair

15. MOTHER'S MAIDEN NAME

Elizabeth

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

216-32-1066

18. INFORMANT

74 N. Madison Lane

Mr. Benjamin C. Rich Newport News, Va. 23606

19. 412.4

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

422.1 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/12/68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8/14/68

24C. NAME of CEMETERY or CREMATORY

Baltimore Cemetery

24D. LOCATION (City, town, or county)

Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 15 1968

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Wm. Cook-Brooks, Inc. 1217 St. Paul St.

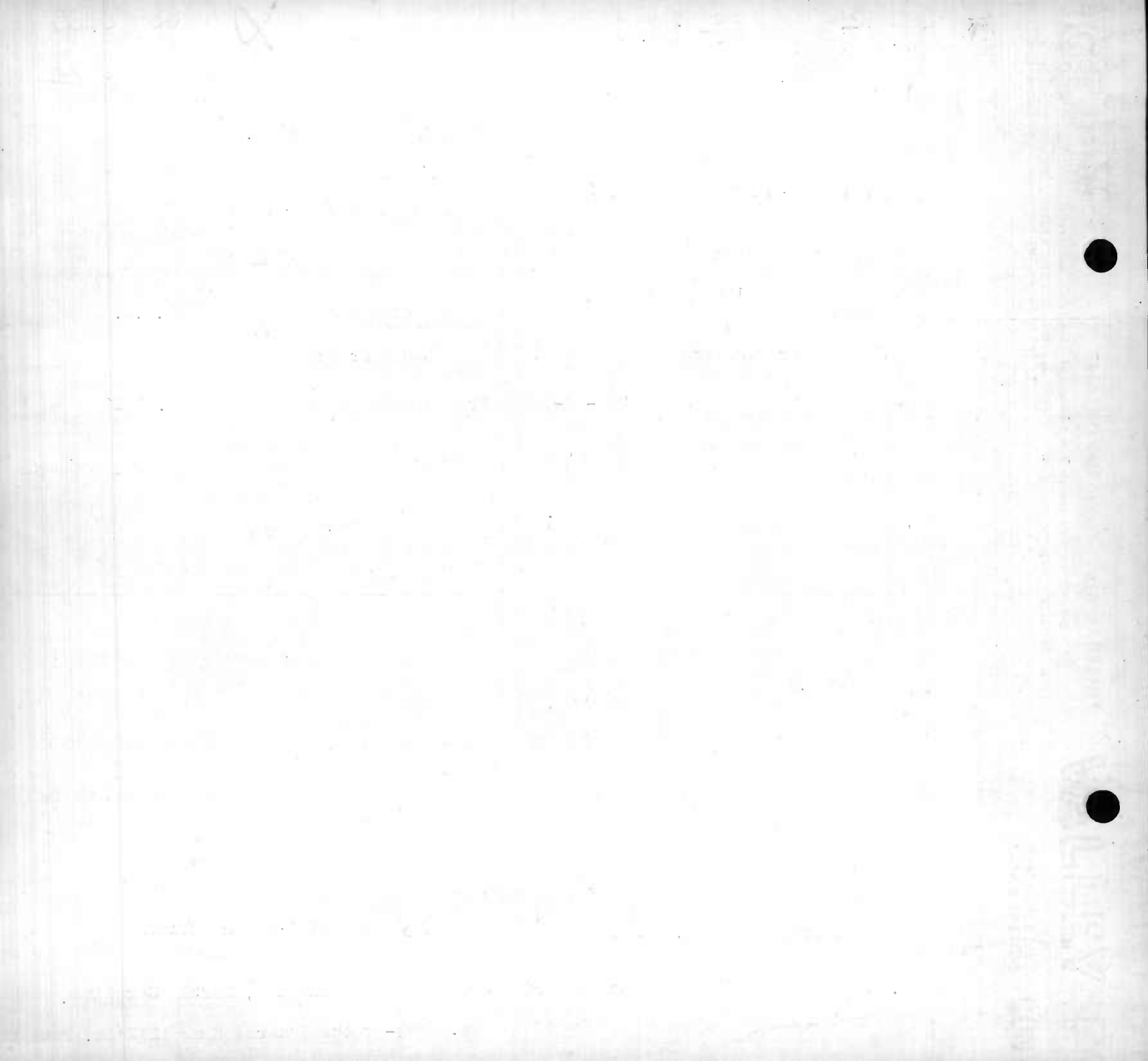
ADDRESS

Handwritten signature or initials.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HENNING, VONNIE Blanche		13 AUG 68 8 10 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital		A. STATE B. COUNTY Maryland Baltimore			
5. SEX Female		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				North Carolina	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
James Henry Woolard		Laura Frances Robinson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		218-14-1430		Fred Henning 8009 Wynnbrook Rd. 21224	
18. 191X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshterio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: POSTERIOR FOSSA HEMORRHAGE (B) HEMANGIOBLASTOMA (C)			
19. 193.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 HOURS			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
12 AUG 68				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5 AUG 19 68 to 13 AUG 19 68, that (I) (we) lost saw the deceased alive on 13 AUG 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Merwyn Bagan		23B. DATE SIGNED 13 Aug 68			
23C. PHYSICIAN'S NAME (Type) Merwyn Bagan, M.D.		23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/15/68		24C. NAME of CEMETERY or CREMATORY Pamlico Memorial Gardens	
24D. LOCATION (City, town, or county) (State) Washington, North Carolina					
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1968		25B. NAME OF REGISTRAR Robert E. Fairburn		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Funeral Home 1217 St. Paul St	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8336 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 68- 8336

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mildred L. Mahle		8/12/68 6:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
The Johns Hopkins Hospital				Maryland Baltimore	
				C. CITY OR TOWN Baltimore	
				1020 Quantril Way	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				1020 Quantril Way 26-34	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2-01-22	47	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				W. VA.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Lee RAINES		MAY Reed.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		235-30-0648			
18. 199.0 I CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				1 month	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES				8 months	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hepatic Failure + Anemia					
(B) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____					
199.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 7/16 19 68 to 8/12 19 68, that (2) (we) last saw the deceased alive on 8/12 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Jeffrey D. Neill M.D.				8/12/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Jeffrey D. Neill M.D.				Johns Hopkins Hospital 601 N. Broadway Balt md 21205	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		8-15-1968		Davis Cemetery	
				Davis, West Virginia	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 15 1968		Robert E. Johnson		Wm. Cook-Brooks, 1217 St. Paul Street Baltimore, Maryland	

A 212

20/3/74

2nd year 1st term

Hepatitis B virus +  
Antibody

Metastatic carcinoma

10

25

21/2 28  
O

21/2 28  
O

21/2

O

O

O

21/2 28

X

Jeffrey D. Hall M.D.

Johns Hopkins Hospital  
601 N. Broadway East Baltimore, MD 21205

Jeffrey D. Hall M.D.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8337 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 68- 8337

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>LASTNER, Frank John (Francis)</b>		2. DATE AND HOUR OF DEATH <b>Aug 12 1968 10:45 A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Prince Georges Co.</b> <b>66-00</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIV. Hospital Balto Md</b> <b>38</b>			C. CITY OR TOWN <b>Greenbelt Md</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>19 P. Ridge Rd</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/20/09</b>	9. AGE (In years last birthday) <b>59</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Prince George Co. govt.</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto Md</b>	
13. FATHER'S NAME <b>Edward LASTNER</b>			14. MOTHER'S MAIDEN NAME <b>Mabel Childs</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWII</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>HILDA C LASTNER GREENBELT-MD.</b>	
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Bronchogenic Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF: <b>with multiple metastases</b> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: _____ (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
162.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/9/68</b> 19 <b>68</b> to <b>8/12</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/12</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>E S Caplan MD</b> DEGREE				23B. DATE SIGNED <b>8/12/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>E. S. CAPLAN</b> DEGREE				23D. ADDRESS <b>Univ Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug 16, 1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
24D. LOCATION <b>Baltimore,</b>		24E. (City, town, or county) (State) <b>Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 15 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>	
				ADDRESS <b>Hyattsville, Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8338

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 8338

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Louis A. Ruffin</b>		2. DATE AND HOUR OF DEATH <b>August 13, 1968</b> <b>5:15</b> a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> 8. COUNTY <b>14-03</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>39</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital, Inc. 1514 Division St. Baltimore, Maryland 21217</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction Work</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>White and Turner</b>		8. DATE OF BIRTH <b>5-18-16</b> 9. AGE (In years last birthday) <b>32</b>	
13. FATHER'S NAME <b>Lewis D. Ruffin</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Burke</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>230-12-3815</b>		17. INFORMANT <b>Mrs. Cora B. Mack (Aunt)</b> ADDRESS <b>Same</b>	
18. <b>412.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Hypertensive Arteriosclerotic</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Heart Disease</b> (B) <b>Pleurisy</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Pneumonitis</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. <b>443X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>August 7, 1968</b> to <b>August 13, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug. 13, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Raymundo R. Corpuz, M.D.</b>				23B. DATE SIGNED <b>8-13-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Raymundo R. Corpuz, M. D.</b>				23D. ADDRESS <b>1514 Division St.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/16/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore National</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		24E. STATE (State) <b>Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 15 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>J. R. Bailey - Director</b> ADDRESS <b>Kelson Funeral Home 1348 Calhoun St.</b>	

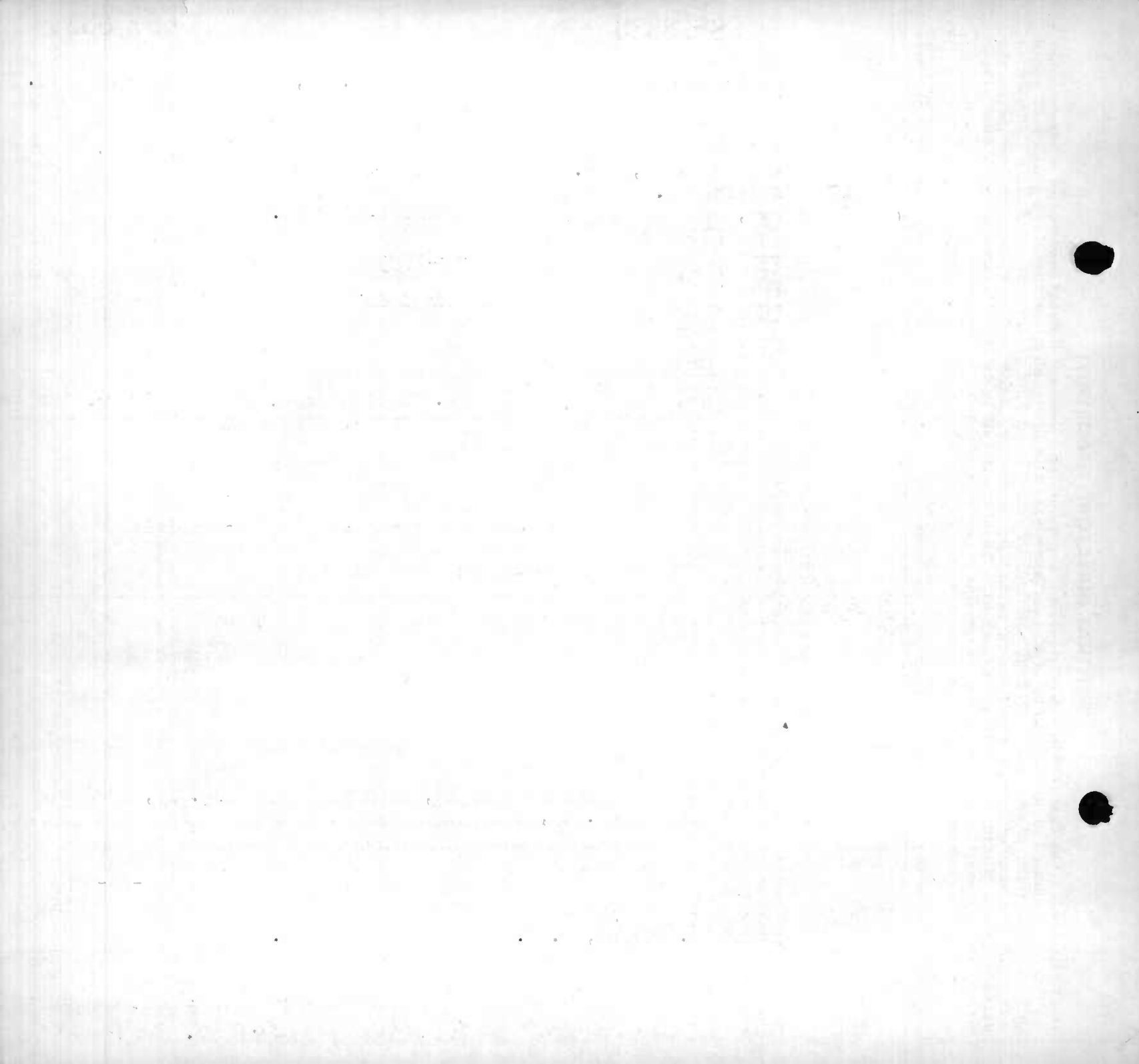


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8339 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH REG. NO. 68- 8339

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Crisstella Woods		Aug. 13, 1968 4:40 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
Provident Hospital, Inc. 1514 Division St. Baltimore, Maryland 21217				Maryland	
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
Female Negro				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				E. STREET AND NUMBER	
				1601 Bakebury Ct.	
10B. KIND OF BUSINESS OR INDUSTRY				9. AGE (In years last birthday)	
				8-8-1903 65	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
Virginia				USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Henry Carlin				May	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
No					
17. INFORMANT ADDRESS					
Mrs. Estella Jones (Friend) 504 Fulton Ave					
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive Arteriosclerotic Heart Disease					
(B) DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Congestion with Pneumonitis					
(C) RHEUMATIC HEART DISEASE					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 28, 1968 to Aug. 13, 1968 that (I) (we) lost saw the deceased alive on Aug. 13, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Raymundo R. Corpuz, M.D.				8-13-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Raymundo R. Corpuz, M.D.				1514 Division St.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/16/68		Mt Auburn	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.			
Baltimore, Maryland		AUG 15 1968			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			
J. R. Bailey		KELSON Funeral Home		1348 N. Calhoun St	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 8340

BIRTH NO.

REG. NO.

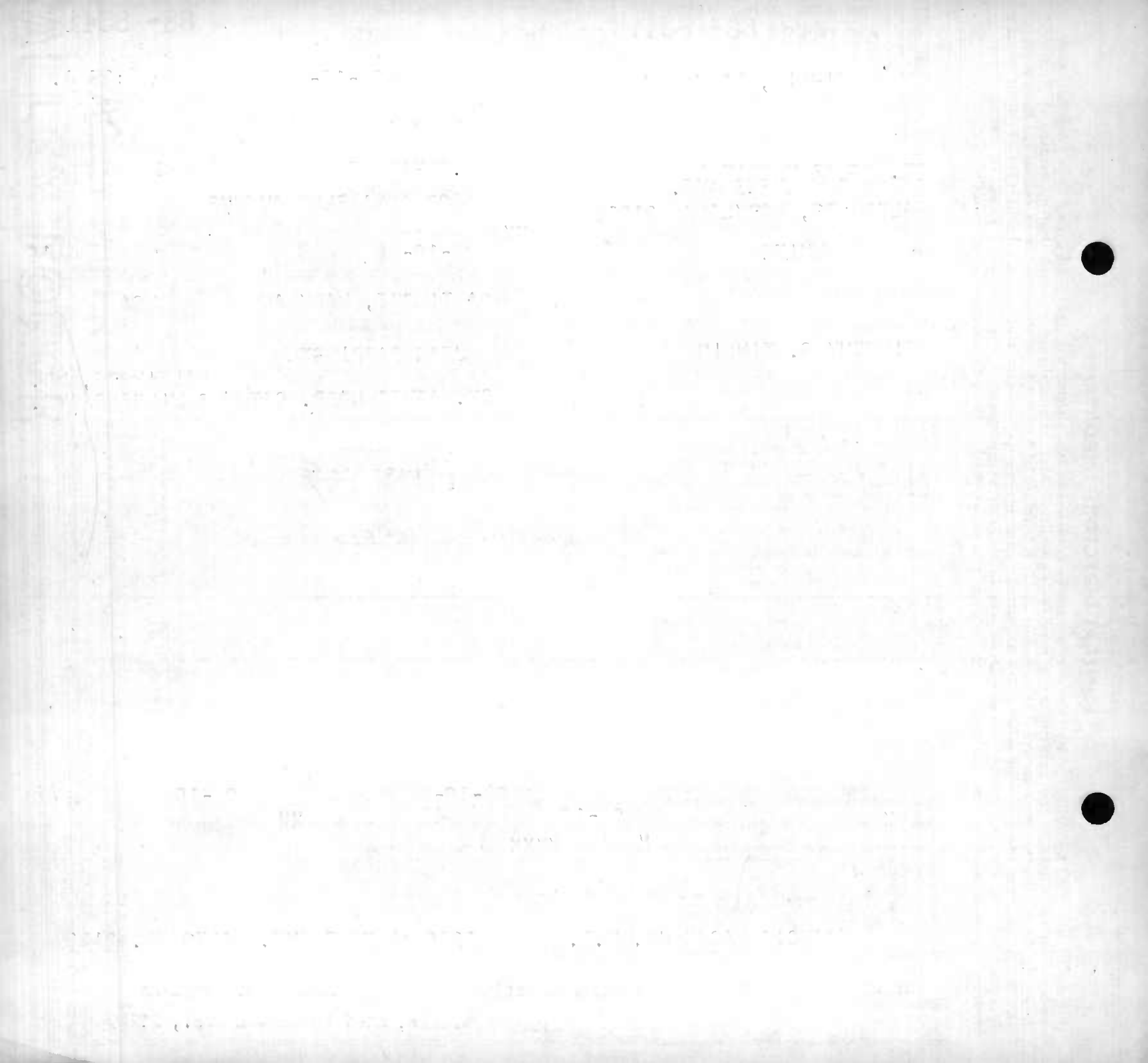
1. NAME OF DECEASED (Type or Print) <b>HALLIE Hogston HALLSTON</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>August 12, 1968 5:20 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2613 Frederick Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 12, 1968 5:20 A.M.</b>	
6. SEX <b>female</b>		7. RACE <b>white</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Nov. 7, 1916</b>		10. AGE (In years last birthday) <b>51</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Hazel Dean</b>		ADDRESS <b>2613 Frederick Ave</b>	
19. <b>412.2</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> DATE SIGNED <b>8/12/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/15/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Beach Fork</b>		24D. LOCATION (City, town, or county) (State) <b>Wharfedale W. Va</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 15 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>	
25C. FUNERAL DIRECTOR <b>Witzke</b>		ADDRESS <b>4101 Edmondson Ave</b>	

الانتماء الى كتيبة

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68- 8341</b>
BIRTH NO. <b>68-15877 68- 8341</b>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>TIMLIN, BABY BOY</b>		2. DATE AND HOUR OF DEATH <b>08-10-68 6:25 A.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL</b> <b>CATON &amp; WILKENS AVE.</b> <b>BALTIMORE, MARYLAND 21229</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER <b>607 ANNABELLE AVENUE</b>		
5. SEX <b>M</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>08-10-68</b>	9. AGE (In years last birthday) <b>15</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>
				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>TIMOTHY G. TIMLIN</b>		14. MOTHER'S MAIDEN NAME <b>JEAN SAPPINGTON</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>BALTIMORE, MD. ST. AGNES HOSP. CATON &amp; WILKENS AVE.</b>
18. <b>761.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>PERITONITIS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>maternal diabetes</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. <b>769.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>08-10-68</b> to <b>08-10-68</b> , that (X) (we) last saw the deceased alive on <b>08-10-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Francis Macek Jr.</i>		23B. DATE SIGNED <b>8-10-68</b>		
23C. PHYSICIAN'S NAME (Type) <b>FRANCIS MACEK JR. M.D.</b>		23D. ADDRESS <b>3350 WILKENS AVE. BALTO MD. 21229</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8/15/68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 15 1968</b>		25B. NAME OF REGISTRAR <i>Robert E. Finkbeiner</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Witzke, 4101 Edmondson Ave., 21229</b>



BALTIMORE CITY HEALTH DEPARTMENT  
68- 8342 CERTIFICATE OF DEATH

REG. NO. 68- 8342

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 5-520		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 8342	
1. NAME OF DECEASED (Type or Print) Eleanor Simms			2. DATE AND HOUR OF DEATH 8-13-68 3 a M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 12-05		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 415 EAST FEDERAL STREET					
5. SEX FEMALE	6. RACE NERGO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10-9-88	9. AGE (In years lost birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-54-4145J		17. INFORMANT ADDRESS RECORD: BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE #21224	
18. 299X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic brain syndrome (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
19. 309X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-12 19 68 to 8-13 19 68, that (I) (we) last saw the deceased alive on 8-12 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Christopher Stuckey M.D.				23B. DATE SIGNED 8-13-68	
23C. PHYSICIAN'S NAME (Type) CHRISTOPHER STUCKEY M.D.				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION Baltimore, Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Charles A. Rice 661 W. Barre St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68- 8343	
BIRTH NO. 68- 8343			68- 8343		
1. NAME OF DECEASED (Type or Print) <b>Jane Klages</b>			2. DATE AND HOUR OF DEATH <b>Aug. 11, 1968 7:45 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 1105 E. Fayette Street</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-2-1876</b>	9. AGE (In years last birthday) <b>92</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Baltimore MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Peter David Klages</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Houston</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216 56 3080</b>	17. INFORMANT ADDRESS <b>Jl Mrs. Freeburger 317 E. 28th St.</b>		
18. <b>412.4 I</b> CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Generalized ASCVD</b>					<b>Sev. Yrs.</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(was not present)</del> attended the deceased from <b>4-24-1964</b> to <b>Aug. 11, 1968</b> , that (I) <del>(was)</del> last saw the deceased alive on <b>Aug. 8, 1968</b> and that in <del>(my)</del> <del>(my)</del> <del>(my)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(did)</del> <del>(did)</del> view the body after death.					
23A. SIGNATURE <b>E. Ellsworth Cook MD</b>				23B. DATE SIGNED <b>Aug. 11, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>E. Ellsworth Cook</b>			23D. ADDRESS <b>MD 2431 Maryland Ave</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>8/14/68 Soudan Pk Cme.</b>		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 15 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fickman</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm J. Tiedner &amp; Sons Balt. MD.</b>	

2

June

Backbone

Small

Small

Small

Small

Small

Small

Small

Small

Small

Small

Small

68- 8344

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 8344

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Vernon E. Gass

2. DATE AND HOUR OF DEATH

8-14-68

4:45 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

44

Union Memorial Hosp  
Baltimore, Md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

63-00

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

9 E Maple Ave

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

4-24-00

9. AGE (In years  
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Tobacco Company

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA.

13. FATHER'S NAME

John L. Gass

14. MOTHER'S MAIDEN NAME

Nellie Amelia ELLIS

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

090-03-5793A

17. INFORMANT

Arna E. Gass same address 9 Maple Avenue 21206

ADDRESS

18. 410.9 + 185 X  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

Myocardial infarction

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Arteriosclerotic cardiovascular  
disease

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

Sudden

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Carcinoma of prostate with metastases sev. years

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At ☐ Not While  
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec 19 67 to August 14 19 68,  
that (I) (we) last saw the deceased alive on 8-14 19 68 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Alfred G. Ossman Jr MD

DEGREE

Attending  
Phys.Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

8-14-68

23C. PHYSICIAN'S  
NAME (Type)

Alfred G. Ossman Jr MD

DEGREE

23D. ADDRESS

1101 St Paul St Balto 2 MD

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

Aug 17, 68

24C. NAME OF CEMETERY or CREMATORY

Loudon Park Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 15 1968

25B. NAME OF REGISTRAR

Robert E. Fairbanks

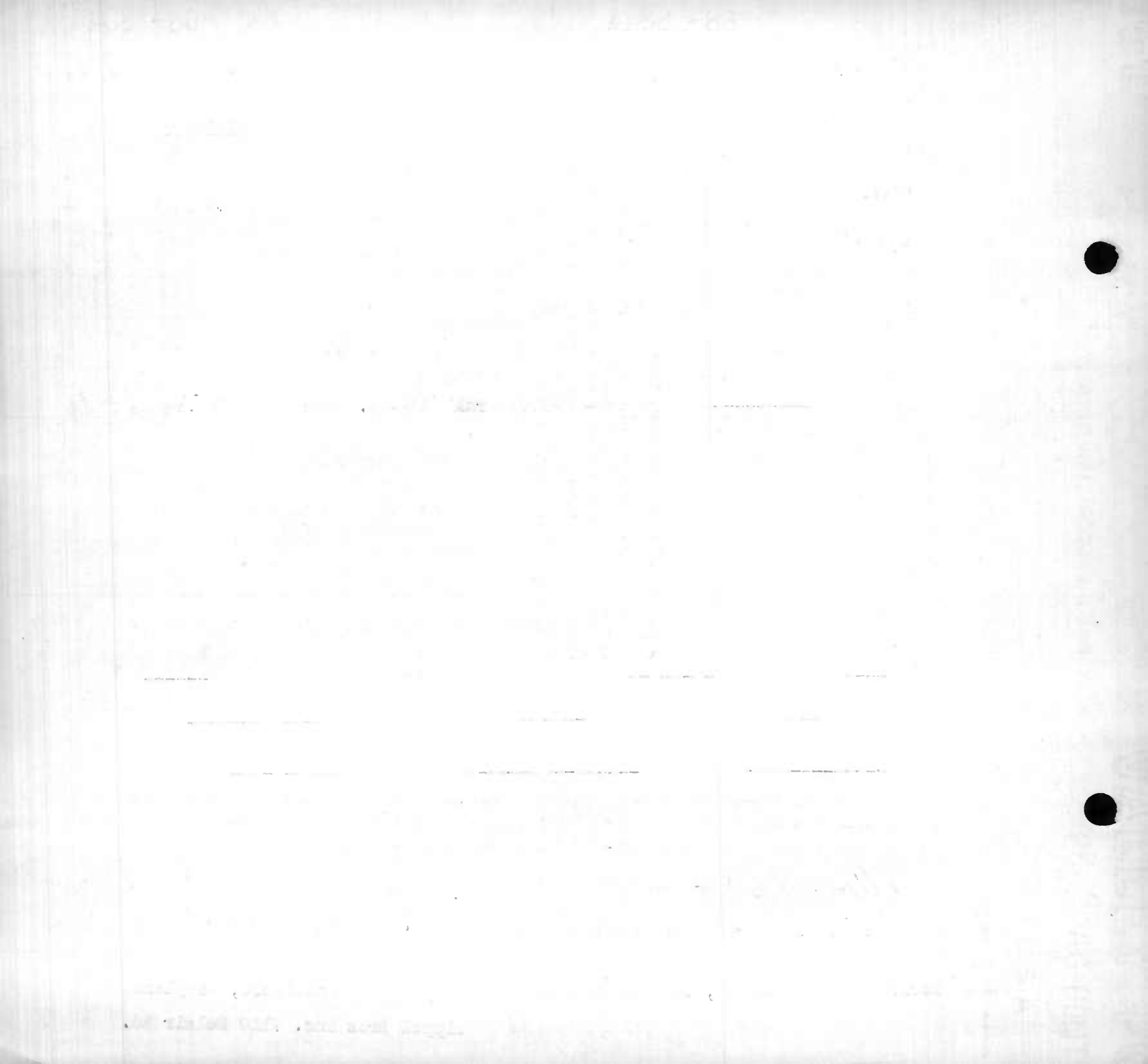
25C. FUNERAL DIRECTOR

Dippel Bros Inc. 7110 Belair Rd.

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8345 CERTIFICATE OF DEATH

REG. NO.

68- 8345

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MABEL LAWRENCE (or) Mabel A. Lawrence</b>		2. DATE AND HOUR OF DEATH <b>AUGUST 13, 1968   8:10 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 The Johns Hopkins Hospital</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>25 Blister St.</b>		<b>Aero Acres</b>
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7/15/11</b>	9. AGE (In years lost birthday) <b>57</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Drug Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Pharmacy</b>		11. BIRTHPLACE (State or foreign country) <b>Petersburg, W. Va.</b>	
13. FATHER'S NAME <b>Perry J. Rohrbaugh</b>			14. MOTHER'S MAIDEN NAME <b>Gertrude F. Burg</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-05-3939</b>		17. INFORMANT <b>Shirley Locklear 25 Blister St. Balto 21228</b>	
18. <b>354 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Midbrain Hemorrhage</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Thrombocytopenia</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Gram neg. sepsis + Acute renal failure</b> (C) DUE TO, OR AS A CONSEQUENCE OF: <b>Guillain Barre Syndrome</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>2 wks</b> <b>6 wks</b>		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>364 X II</b>					
19A. DATE OF OPERATION <b>6/29</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Guillain Barre Syndrome</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>7/1</b> 19 <b>68</b> to <b>8/13</b> 19 <b>68</b> , that (1) (we) last saw the deceased alive on <b>8/13</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jeffrey D. Neill M.D.</b> DEGREE				23B. DATE SIGNED <b>8/13/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jeffrey D. Neill M.D.</b> DEGREE				23D. ADDRESS <b>Johns Hopkins Hospital 601 N. Broadway Balt. Md. 21205</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug 16, 68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith Cem</b>	
24D. LOCATION <b>Baltimore Co., Maryland</b>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 15 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. J. [unclear]</b>		25C. FUNERAL DIRECTOR <b>Dippel Brothers Inc. 1800 E. Lombard St.</b>	
25D. ADDRESS					

X

Midbrain Hemorrhage

Thrombotic

Green red. spots + white central

(Willian Lane 2nd edition)

Willian Lane 2nd edition 1922

1922

1918

1918

1918

1918

1918

1918

1918

X

Jeffrey R. Hall M.D.

Jeffrey R. Hall M.D.

100 M. University Hall + 100

68- 8346

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8346

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)BARTOW  
BARTON JONES JR.2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

8

14

68

4:00 a. M.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

August

14

1968

4:00 a.m.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Sept. 2, 1925

10. AGE (In years  
lost birthday)

42

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

6820 Banks St.

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Bartow Jones Sr.

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Loader

14B. KIND OF BUSINESS OR INDUSTRY

Koesters Bakery

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

241-22-9815

18. INFORMANT

ADDRESS

21219

Mrs. Joanne Justice Route 10, Box 48B, Md.

19.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Diabetes Mellitus

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 14, 1968

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8-17-1968

24C. NAME of CEMETERY or CREMATORY

Loudon Park

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 15 1968

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.

ADDRESS

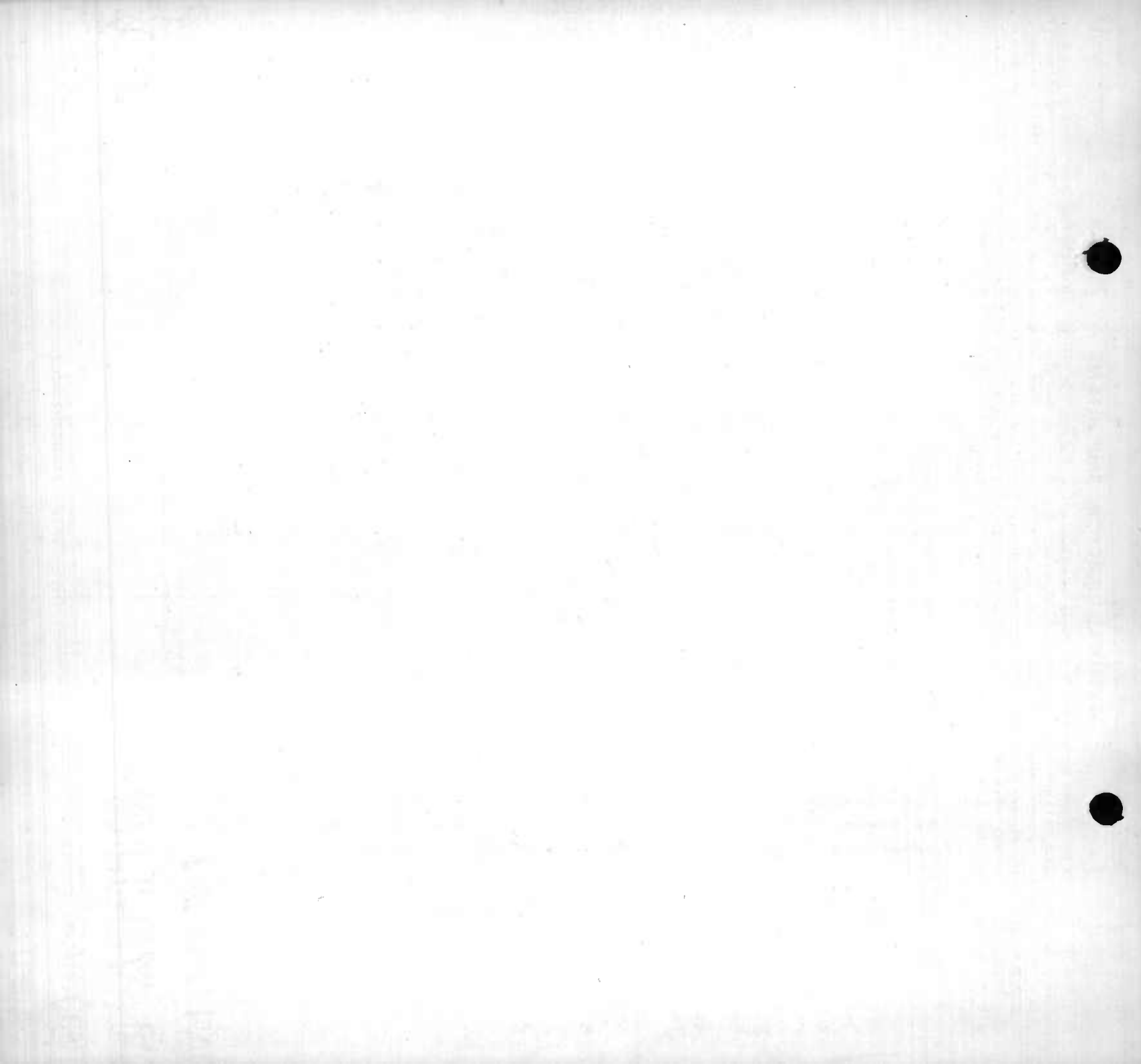
Letter from atty.re error in given name of deceased--Father's name correct on cert.

CERTIFICATE AMENDED

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		68- 8347 CERTIFICATE OF DEATH		REG. NO. 68- 8347	
1. NAME OF DECEASED (Type or Print) <u>Lara Bailey</u>		2. DATE AND HOUR OF DEATH <u>8/10/68</u> <u>12</u> <u>45</u> P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u> <u>38</u>		A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? <u>YES</u> <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
		E. STREET AND NUMBER <u>423 N. Eutan St.</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7/25/18</u>	9. AGE (In years last birthday) <u>49</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown - Edna Smith</u>		14. MOTHER'S MAIDEN NAME <u>Unknown Mary Francis Johnson</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>244-26-8239</u>		17. INFORMANT <u>Plc. 2</u> ADDRESS <u>Sub. 7. Smith Washington D.C.</u>	
18. <u>381.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the made of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) <u>Hypovolemia, Shock</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hypovolemia, Shock</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cirrhosis + Hypersplenism</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Cirrhosis + Hypersplenism</u>		(C).....	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>381.0 II</u>					
19A. DATE OF OPERATION <u>8/7/68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Hypersplenism</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/15/68</u> 19 to <u>8/10/68</u> 19, that (I) (we) last saw the deceased alive on <u>8/10/68</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>DeWitt Kemp MD</u>				23B. DATE SIGNED <u>8/10/68</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>8/16/68</u>		24C. NAME of CEMETERY or CREMATORY <u>River Plain Church Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>4 Raleigh N.C.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 15 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	
25C. FUNERAL DIRECTOR <u>Wm J. Tucker &amp; Sons</u>		25D. ADDRESS <u>Baltimore Md.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 68- 8348 CERTIFICATE OF DEATH

REG. NO.

68- 8348

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Charles Henry Myers

2. DATE AND HOUR OF DEATH

Aug. 12, 1968

7: 03 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

US Public Health Service Hospital  
3100 Wyman Pk. Drive

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Pa.

C. CITY OR TOWN

Uniontown

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

11 Trump Ave.

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

12/26/99

9. AGE (In years lost birthday)

68

If Under 1 Yr. Months: Days

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Supply clerk

10B. KIND OF BUSINESS OR INDUSTRY

Bottled Gas Co.

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William Myers

14. MOTHER'S MAIDEN NAME

Anne Daniels

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

210-09-8314

17. INFORMANT

Records- US PHS Hospital, Balto, Md.

ADDRESS

18.

206.01

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Aspiration

(B) DUE TO, OR AS A CONSEQUENCE OF:

Bacteremia

(C) Acute monocytic leukemia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Terminal

3 days

8 wks.

204.02 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Fibrinous pericarditis

2 days

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 22 19 68 to Aug. 12 19 68, that (I) (we) last saw the deceased alive on Aug. 12 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

John C. Sutherland

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

8/13/68

23C. PHYSICIAN'S NAME (Type)

John C. Sutherland, MD

23D. ADDRESS

US PHS Hospital, Balto, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/16/68

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

Uniontown, Pa.

25A. DATE RECEIVED BY HEALTH DEPT.

AUG 15 1968

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Wm. J. Tichauer & Son, Balto, Md.

ADDRESS

20. 10/10/73

10/10/73

10/10/73

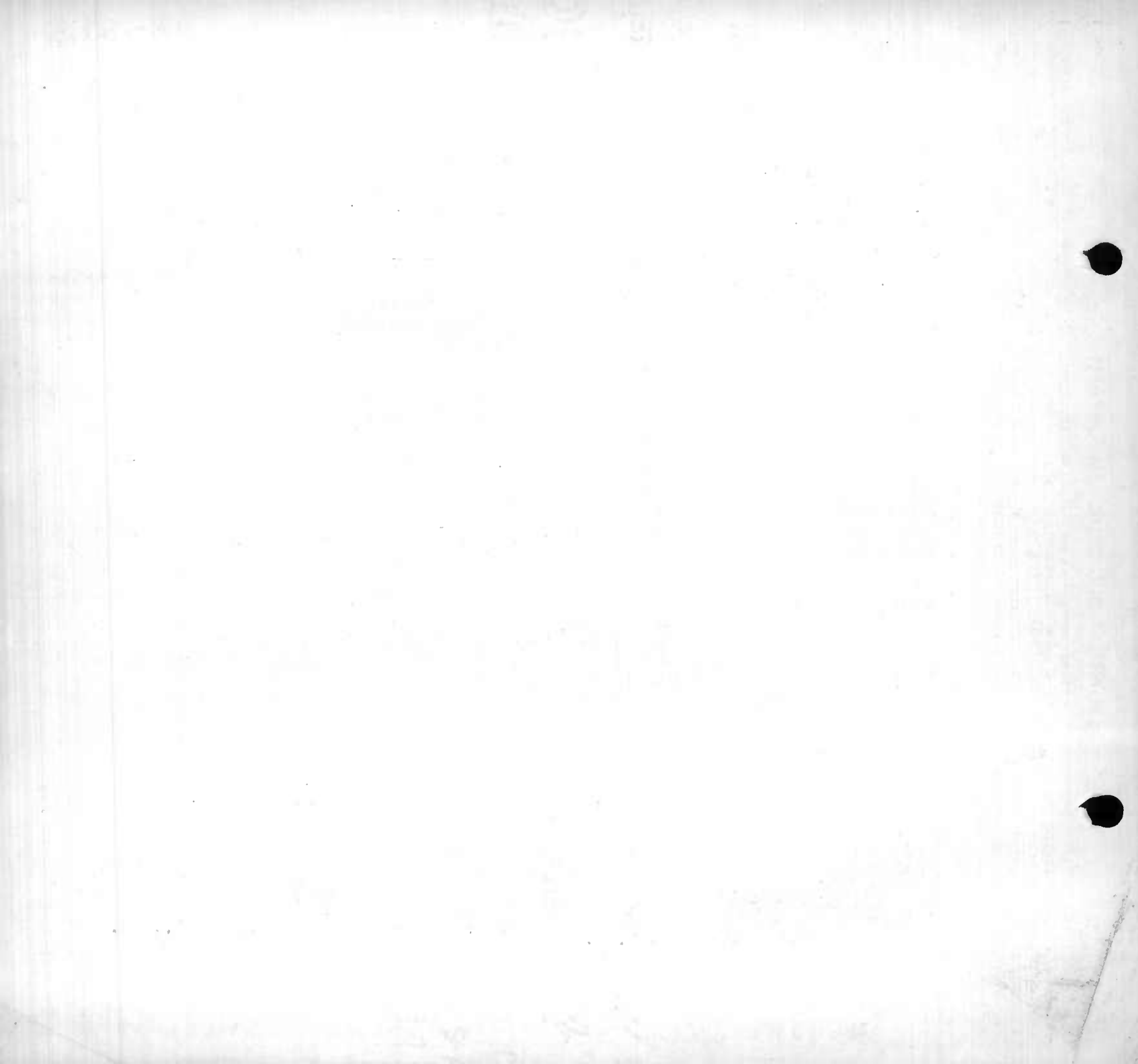
10/10/73

10/10/73

FUNERAL DIRECTOR: IMPORTANT

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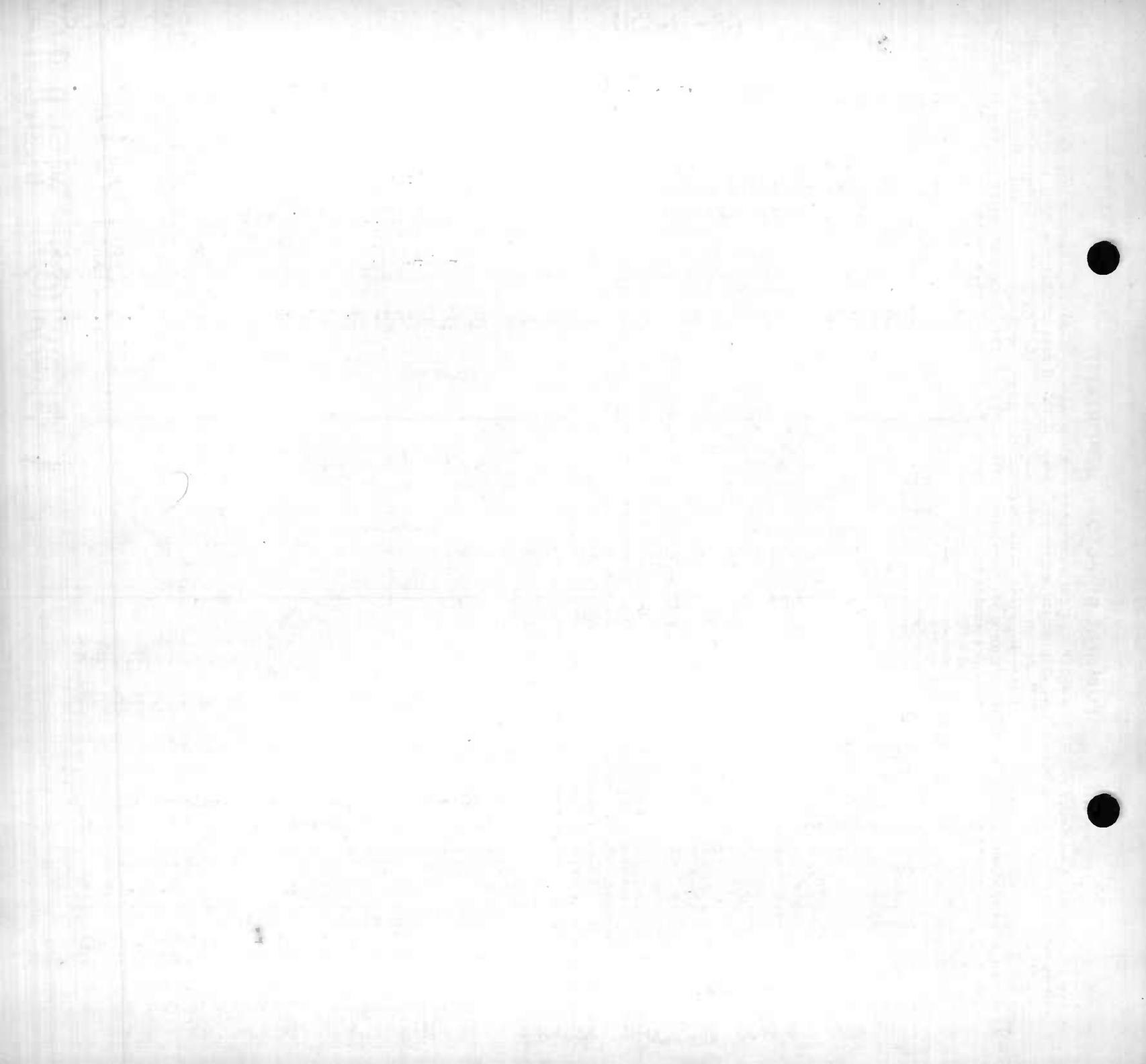
<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="font-size: 24pt; font-weight: bold;">68- 8349</p> <p style="font-size: 24pt; font-weight: bold;">CERTIFICATE OF DEATH</p>		<p>REG. NO. <b>68- 8349</b></p>	
<p>BIRTH NO. <b>K-612</b></p>		<p>1. NAME OF DECEASED (Type or Print) <b>JOHN KARPUS</b></p>	
<p>2. DATE AND HOUR OF DEATH <b>8-1-68 9:15 A.M.</b></p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2318 East Fairmont Avenue #21224</b></p>	
<p>5. SEX <b>Male</b></p>	<p>6. RACE <b>White</b></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>5-14-03</b> 9. AGE (In years last birthday) <b>65</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	
<p>11. BIRTHPLACE (State or foreign country) <b>Ukraine</b></p>		<p>12. CITIZEN OF WHAT COUNTRY?</p>	
<p>13. FATHER'S NAME <b>Sigmund</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Sophie</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO.</p>	
<p>17. INFORMANT <b>BCH Records: 4940 Eastern Avenue Baltimore, Maryland #21224</b></p>		<p>ADDRESS</p>	
<p>18. <b>492 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease or injury or complication which caused death.) <b>Aspiration</b></p>		<p>CAUSE OF DEATH IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Chronic obstructive emphysema</b></p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last.</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>10 yrs</b></p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>BPH</b></p>		<p><b>Benign Prostatic Hypertrophy</b></p>	
<p>19A. DATE OF OPERATION <b>7-31</b></p>	<p>19B. CONDITION WHEN OPERATION WAS PERFORMED</p>	<p>20A. AUTOPSY? (Yes or No) <b>NO</b></p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>	<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>7-24</b> 19 <b>68</b> to <b>8-1</b> 19 <b>68</b>, that (I) (we) last saw the deceased alive on <b>8-1</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>Martin Leibowitz, M. D.</b></p>		<p>23B. DATE SIGNED <b>8-1-68</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>Martin Leibowitz, M. D.</b></p>		<p>23D. ADDRESS <b>BCH: 4940 Eastern Avenue, Balto., Md. #21224</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p>	<p>24B. DATE <b>8-13-68</b></p>	<p>24C. NAME OF CEMETERY or CREMATORY</p>	<p>24D. LOCATION (City, town, or county) (State) <b>ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</b></p>
<p>25A. DATE REC'D BY HEALTH DEPT. <b>AUG 15 1968</b></p>	<p>25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b></p>	<p>25C. FUNERAL DIRECTOR ADDRESS</p>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8350 4	
BIRTH NO. 08-13286		68- 8350		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) Pratt, B. C. Janie Mae			2. DATE AND HOUR OF DEATH 7-20-68 18:40 p. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital 1514 Division Street Baltimore, Maryland			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 1208 McCulloh Street					
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-20-68	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 5 30
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Ernest Pratt		
14. MOTHER'S MAIDEN NAME Janie Mae Fletcher			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
18. 238.7 I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Intrauterine Infection					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
268.5 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-20-68 19 to 7-20-68 19, that (I) (we) last saw the deceased alive on 7-20-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. G. Stevens			23B. DATE SIGNED 7-20-68		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) M. G. Mercado, M.D.			23D. ADDRESS Provident Hospital 1514 Division Street Baltimore, Maryland		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8-13-68		24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL	
24D. LOCATION (City, town, or county) (State)		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1968		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHD	



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68- 8351 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8351

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOHN J. STYER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>July 28, 1968</b> Hour <b>5:25 P.</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 24 E. Preston Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>5:25 P.</b> M.	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH		10. AGE (In years lost birthday) <b>58</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME		E. STREET AND NUMBER <b>24 E. Preston Street</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. <b>011, 21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Chronic Lung Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Far Advanced Tuberculosis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>July 29, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>8-15-68</b>	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) <b>UNIVERSITY MEDICAL SCHOOL</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 15 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>	
25C. FUNERAL DIRECTOR		ADDRESS <b>MORTUARY SERVICE - BCHD</b>	

11-

8-21-8

R-100

68- 8352 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 8352

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CLINTON RAPP

2. DATE  
OF  
DEATHKnown ☒  
Estimated ☐Month  
Day  
YearHour  
Minute  
SecondHour  
Minute  
Second

7

14

68

1:35 a

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 1210 N. Calvert Street D.O.A.

3. DATE  
PRONOUNCED DEADMonth  
Day  
YearHour  
Minute  
Second

July

14

1968

1:35 a

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS

YES ☒NO ☐

9. DATE OF BIRTH

10. AGE (In years  
last birthday)  
55If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1210 N. Calvert St.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

19. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

Hypertensive arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

20. ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

8-15-68

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

AUG 15 1968

Robert E. Finkbeiner

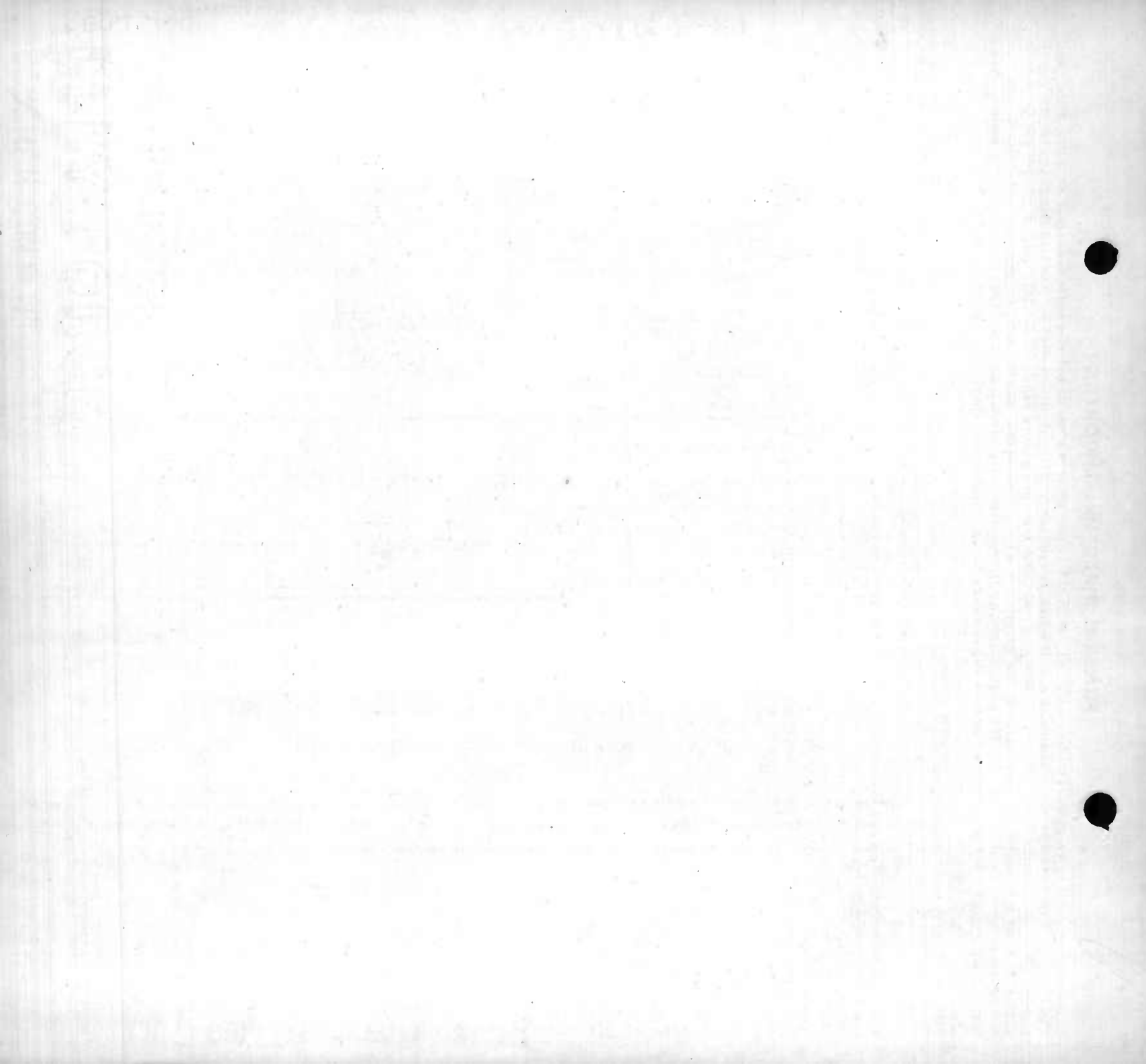
MORTUARY SERVICE - BCHD

8-12-58

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 8353	
BIRTH NO. 68-14709		68- 8353	
1. NAME OF DECEASED (Type or Print) <i>Baby Girl Holley B</i>		2. DATE AND HOUR OF DEATH <i>8/7/68 9 A M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Union Memorial Hospital</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>9-01</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>1839 E 29th</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/7/68</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Baby</i>		10B. KIND OF BUSINESS OR INDUSTRY —	9. AGE (In years last birthday) <i>5</i>
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Royal D. Holley</i>		14. MOTHER'S MAIDEN NAME <i>Julia Witherspoon</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>NO</i>	
17. INFORMANT <i>NO</i>		ADDRESS	
18. <i>769.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Cardiorespiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Prematurity</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>C/S</i>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>774 X II</i>			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>NO</i>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>8/7</i> 19 <i>68</i> to <i>8/7</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>August 7</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.			
23A. SIGNATURE <i>Andrew Sun M.D.</i>		23B. DATE SIGNED <i>8/7/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>ANDREW SUN M.D.</i>		23D. ADDRESS <i>Union Memorial Hospital Baltimore</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>8/12/68</i>		24B. DATE	
24C. NAME OF CEMETERY or CREMATORY <i>JOHNS HOPKINS MEDICAL SCHOOL</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 15 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, Jr.</i>	
25C. FUNERAL DIRECTOR <i>MORTUARY SERVICE - BCHD</i>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8354 4	
BIRTH NO. 68-14708		68- 8354		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Baby girl Holley A			2. DATE AND HOUR OF DEATH 8/17/68 5 A.M.		
3. PLACE IN BALTIMORE (MAYLAND, WHERE PRONOUNCED DEAD)			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital			C. CITY OR TOWN Baltimore		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 1839 E 29th STREET					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/7/68	9. AGE (In years lost birthday) 1 hr	10. CITIZEN OF WHAT COUNTRY? U.S.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Union Memorial H.	
13. FATHER'S NAME Royal Holley			14. MOTHER'S MAIDEN NAME Julia Witherspoon		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 427.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio respiratory arrest		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Prematurity DUE TO, OR AS A CONSEQUENCE OF: CS		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 774X II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/7/68 to 8/7/68, that (I) (we) last saw the deceased alive on 8/7/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Andrew Sun M.D.			23B. DATE SIGNED 8/17/68		23C. PHYSICIAN'S NAME (Type) Andrew Sun M.D.
23D. ADDRESS Union Memorial Hospital Balto.			24A. BURIAL CREMATION, REMOVAL (Specify) 8-12-68		
24B. DATE 8-12-68			24C. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL SCHOOL		
24D. LOCATION MORTUARY SERVICE - BCHD			25A. DATE REC'D BY HEALTH DEPT.		
25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8355

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 8355

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MUHL, GLADYS</b>		2. DATE AND HOUR OF DEATH <b>8-14-68</b> <b>12<sup>45</sup> A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>21216</b>		5. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL OF MARYLAND.</b>		E. STREET AND NUMBER <b>3506 Abbie Place</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-15-1898</b>	9. AGE (In years lost birthday) <b>70</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Carroll Co, Maryland</b>	
13. FATHER'S NAME <b>William Stansbury</b>		14. MOTHER'S MAIDEN NAME <b>Powder</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>Zeno W. Muhl-6813 Yataruba Drive</b>	
18. <b>412.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Atrial fibrillation Hypertensive Atherosclerotic Cardio</b> (B) <b>Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Acute Respiratory infection</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>443X II</b>		<b>HYPOTHYROIDISM</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>8-4-1968</b> to <b>8-14-1968</b> , that (I) (we) last saw the deceased alive on <b>8-14-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>Dr. T.K. SATYAVRITHAN.</b>	
23D. ADDRESS <b>LUTHERAN HOSPITAL OF MARYLAND BALTO. MD 21216</b>		23E. ADDRESS <b>Ellsworth Armacost-4600 Liberty Hghts. Av</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-17-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		24E. DATE REC'D BY HEALTH DEPT. <b>AUG 15 1968</b>		24F. NAME OF REGISTRAR <b>Robert E. [Signature]</b>	

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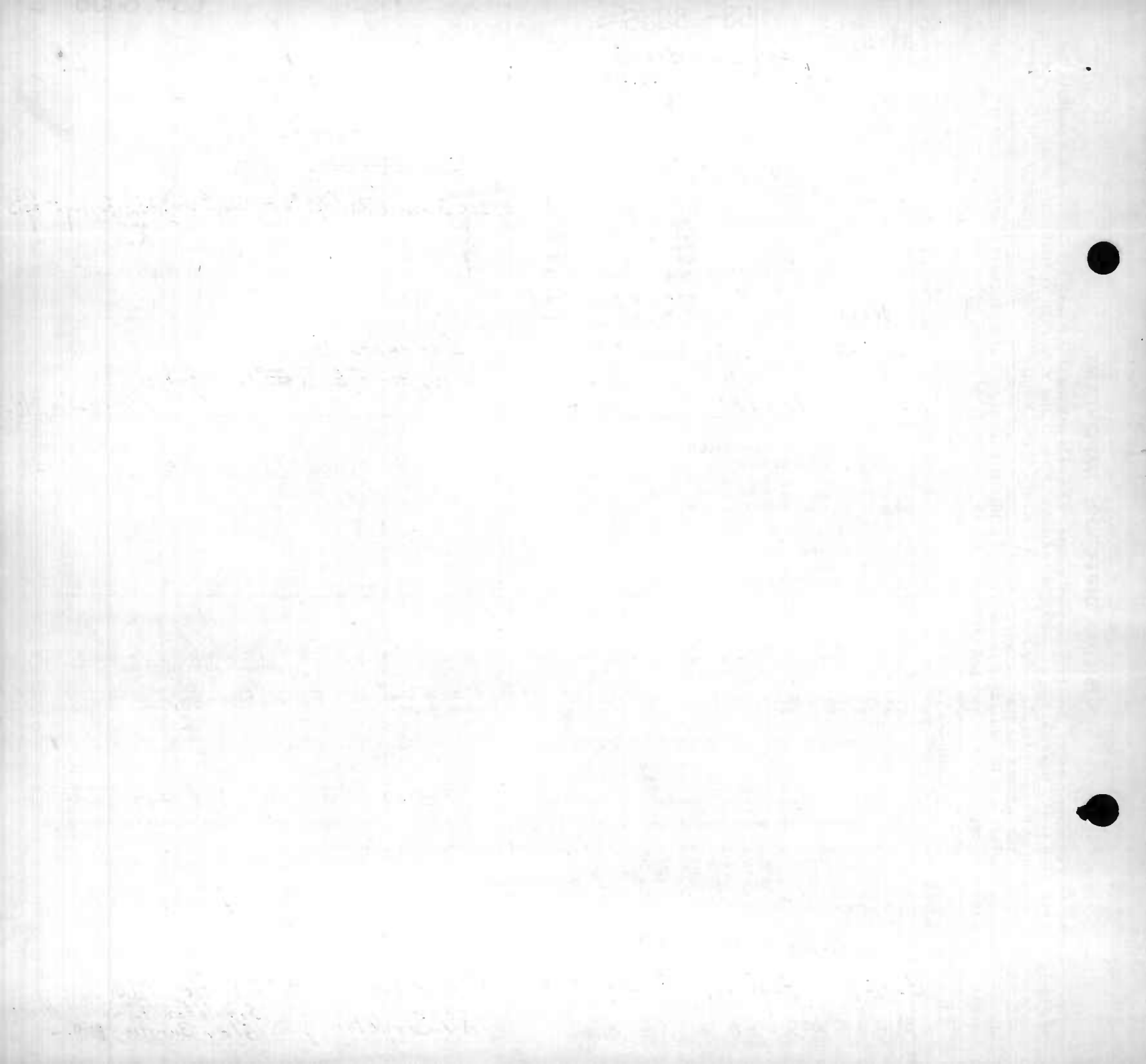
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68- 8356	68- 8356
CERTIFICATE OF DEATH				REG. NO.	X
1. NAME OF DECEASED (Type or Print) <b>BABY GIRL MAC KOWN</b>		2. DATE AND HOUR OF DEATH <b>8/8/68</b>		8 40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Anne Arundel Co.</b> C. CITY OR TOWN <b>Annapolis</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>200 Boxwood Rd. (Apt. #164, Bldg. #200) Adm. Farragut Apts</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/5/68</b>	9. AGE (In years lost birthday) <b>0</b> Months <b>3</b> Days	If Under 1 Yr. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>111111111</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>ALFRED MAC KOWN</b>		14. MOTHER'S MAIDEN NAME <b>Corretta Gies</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>111111</b>		17. INFORMANT <b>Mr. Walter F. Gies (Grandfather)</b> <b>HOSPITAL RECORD</b>	
18. <b>776.1</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>HYALINE MEMBRANE DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>PREMATURITY</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>773.5 II</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/5/68</b> 19 to <b>8/8/68</b> 19, that (I) (we) last saw the deceased alive on <b>8/8/68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Alan Mitnick, M.D.</b>				23B. DATE SIGNED <b>8/8/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALAN MITNICK, M.D.</b>				23D. ADDRESS <b>SINAI HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug-10-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Our Lady of the Field Church Cem</b>	
24D. LOCATION <b>Mt. Vernon, Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>AUG 15 1968</b>		24F. NAME OF REGISTRAR <b>R. V. Singleton</b>	
24G. FUNERAL DIRECTOR <b>Singleton Funeral Home</b>		24H. ADDRESS <b>Glenn Burnie, Md.</b>		24I. STATE <b>Md.</b>	



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H-230 68-8357 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 68-8357

BIRTH NO. \_\_\_\_\_ REG. NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>RAYMOND HACKETT</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>August 13, 1968</b> Hour <b>1:15 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Mercy Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>August 13, 1968</b> Hour <b>1:50 P.M.</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>4-01</b>	
9. DATE OF BIRTH <b>4-12-1913</b>		10. AGE (In years last birthday) <b>55</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>2nd Mate U. S. Merchant Marine</b>		13. FATHER'S NAME <b>John J. Hackett</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		15. MOTHER'S MAIDEN NAME <b>Anna Hawkins</b>	
17. SOCIAL SECURITY NO. <b>Unknown</b>		18. INFORMANT <b>Helen H. Seehuser, 76 Glen Oaks Rd. Rye N.Y.</b>	
19. <b>67181</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Fatty Alteration of Liver</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>5810</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>2</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> <b>Partial Autopsy</b> <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> DATE SIGNED <b>8/13/68</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-17-68</b>	
24C. NAME of CEMETERY or CREMATORY <b>St. Raymonds Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Bronx, New York</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 15 1968 Robert S. Finkbeiner</b>		25B. NAME OF REGISTRAR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>	

VS 151-REV. 1/1/68

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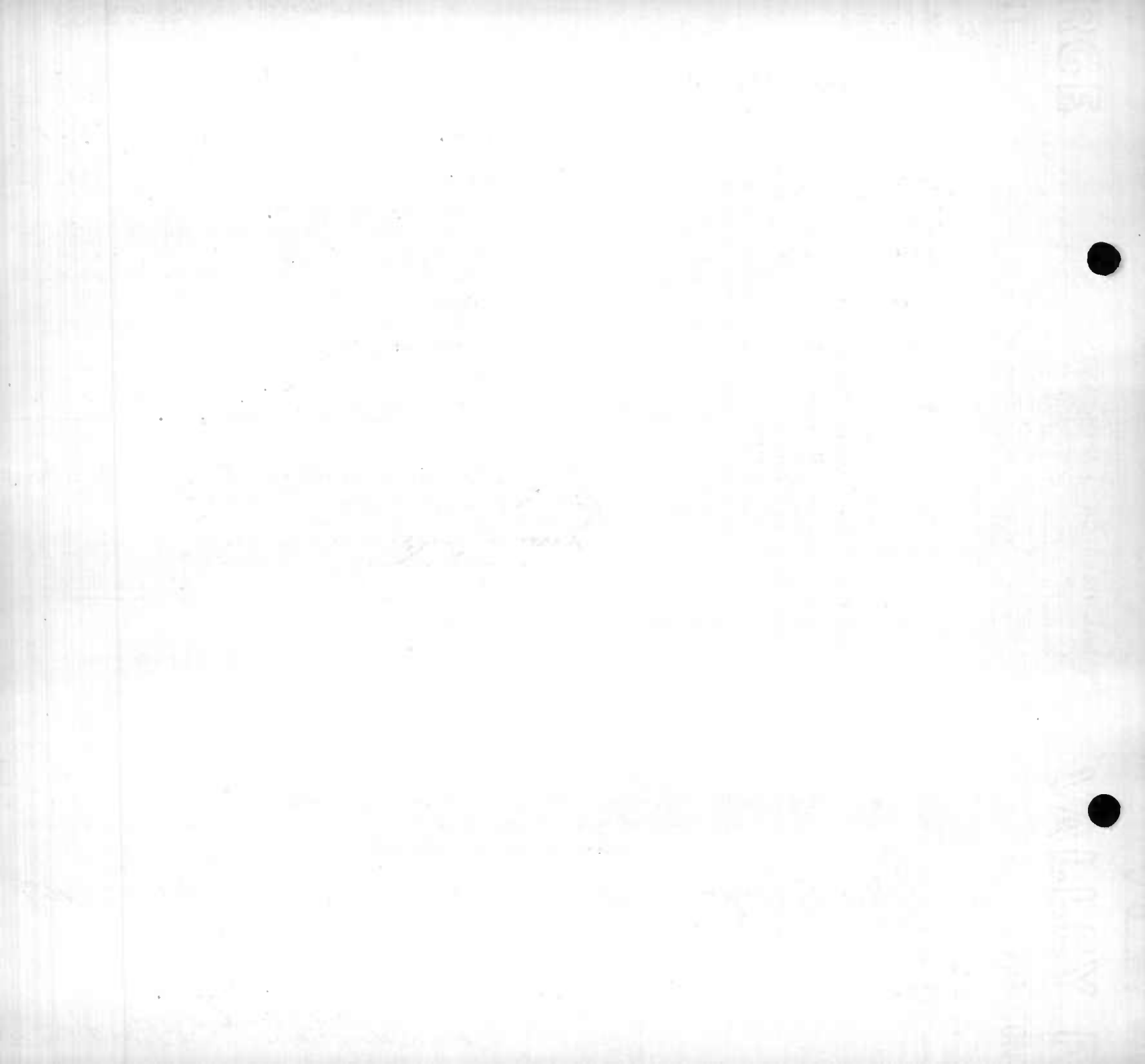
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

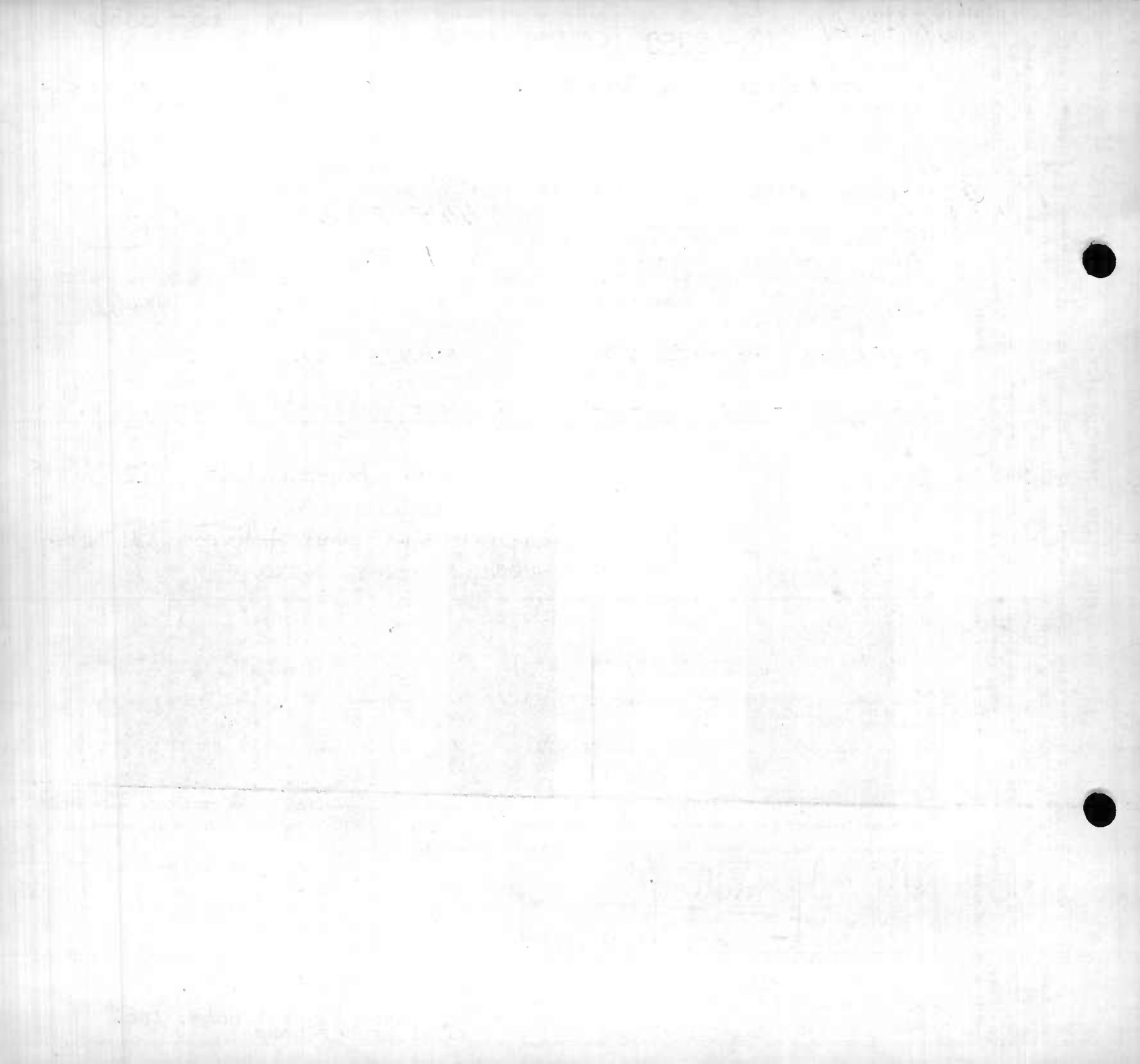
<div style="display: flex; justify-content: space-between;"> <span>S-360</span> <span>68-8358</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <span style="font-size: 2em;">68-8358</span>	
1. NAME OF DECEASED (Type or Print) <b>Larry Noble Sauter</b>		2. DATE AND HOUR OF DEATH <b>August 9 1968</b> <span style="float: right;">8:30 P M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>D.O.A. ST AGNES HOSPITAL</b> <b>40</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore Co.</b> <span style="float: right;">53.00</span> C. CITY OR TOWN <b>Woodlawn</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>Box 573 Dogwood Rd.</b>	
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/20/1949</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>student</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>18</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Noble Sauter</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Able</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>212 56 9720</b>	
17. INFORMANT <b>Noble Sauter</b>		ADDRESS <b>Box 573 Dogwood Rd, Baltimore 7, Md.</b>	
18. <b>518X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>(A) IMMEDIATE CAUSE (Sudden shortness of breath) probably due to Pulmonary Embolism</b> <b>(B) Probable Bronchitis with Probable cystic fibrosis of Pancreas</b> <b>(C)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 hours</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>526X II</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 1962</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>Aug 9 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did not) view the body after death.			
23A. SIGNATURE <b>Robert B Taylor MD</b>		23B. DATE SIGNED <b>Aug 12, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>Robert B Taylor</b>		23D. ADDRESS <b>Ellicott City, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>	24B. DATE <b>8/13/68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Good Shepherd</b>	24D. LOCATION (City, town, or county) (State) <b>Ellicott City, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 15 1968</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	25C. FUNERAL DIRECTOR <b>Wiggin &amp; Sons</b>	ADDRESS <b>Ellicott City, Md.</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-8359</b>	
M-261		68-8359		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>McGreevy Mr. David S.</b>		2. DATE AND HOUR OF DEATH <b>8-11-1968 11:05 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>CHURCH HOME AND HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		C. CITY OR TOWN <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME AND HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>3-1-00</b>		9. AGE (In years last birthday) <b>68</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>own business</b>		11. BIRTHPLACE (State or foreign country) <b>MD Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY? <b>AMER</b>		13. FATHER'S NAME <b>CHARLES McGREEVY</b>		14. MOTHER'S MAIDEN NAME <b>MAMIE WALLACE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WW 1-Army 218-18-1538</b>		16. SOCIAL SECURITY NO. <b>218-18-1538</b>		17. INFORMANT <b>Margaret Marshall McGreevy, wife, above</b>	
18. <b>4-10-01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial infarction</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hyperkalemia and Arterio-sclerotic heart disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>	
19. <b>42017 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>7-29-1968</b> to <b>8-11-1968</b> , that <del>the</del> (we) last saw the deceased alive on <b>8-11-1968</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>My</del> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. Midirix</b>		23B. DATE SIGNED <b>8-11-1968</b>		23C. PHYSICIAN'S NAME (Type) <b>JOSEPH M. MIDIRIX</b>	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/16/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Cemetery</b>		24D. LOCATION <b>Baltimore, Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>AUG 15 1968</b>	
24F. NAME OF REGISTRAR <b>Robert E. Johnson</b>		24G. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		24H. ADDRESS <b>3331 Brehms Lane</b>	



1

C-552 68- 8360 BALTIMORE CITY HEALTH DEPARTMENT

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

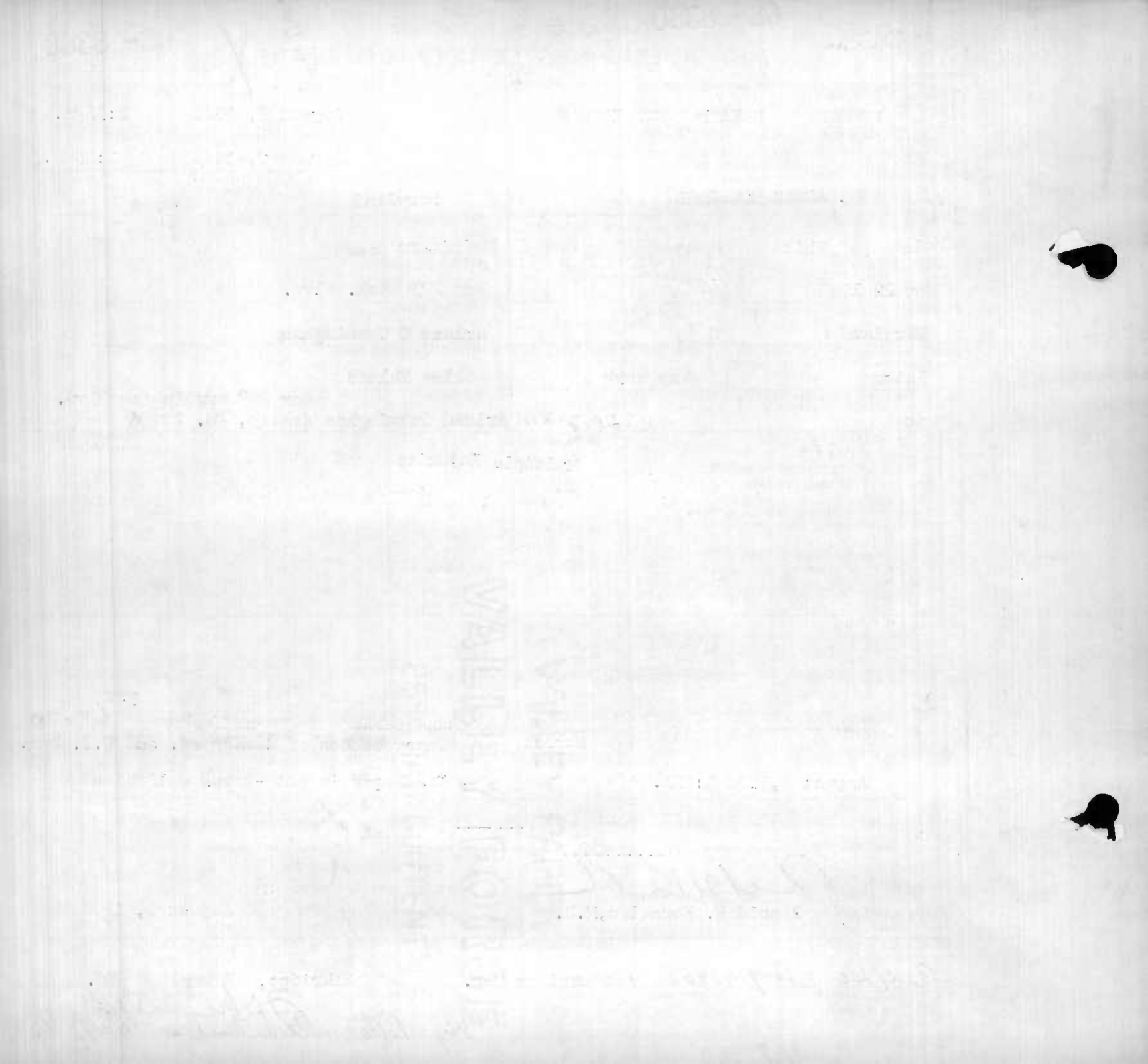
68- 8360

BIRTH NO. REG. NO.

1. NAME OF DECEASED (Type or Print) <b>GEORGE EDWARD CUNNINGHAM</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>August 9, 1968</b>		Hour <b>2:55 A.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>40 ST. AGNES HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>August 9, 1968</b>		Hour <b>2:25 A.</b>
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Howard</b>		<b>63-00</b>		
6. SEX <b>Male</b>	7. RACE <b>White</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>Nov 22 1948</b>		10. AGE (In years lost birthday) <b>19</b>		E. STREET AND NUMBER <b>Box 293 Wash. Blvd.</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Arland D Cunningham</b>
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Day work</b>		15. MOTHER'S MAIDEN NAME <b>Ellen Malone</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>? 214-52-7845</b>		18. INFORMANT <b>Box 293 Washington Blvd. Arland Cunningham Jessup, Md. 20794</b>
19. <b>E 812.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Multiple Injuries</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Intersection of Gorman Rd. and U.S. Rte.</b>
22D. TIME OF INJURY (APPROX.) <b>August 9, 1968 1:15A</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Passenger in auto-truck collision</b>
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> M.D. EXAMINER'S NAME (Type)  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>August 9, 1968</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>Aug 11, 1968</b>		24C. NAME of CEMETERY or CREMATORY <b>Meadowridge Mem.</b>
24D. LOCATION (City, town, or county) (State) <b>Elkridge, Howard Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 15 1968</b>		
25B. NAME OF REGISTRAR <b>Ronald N. Kornblum</b>		25C. FUNERAL DIRECTOR <b>Hyman Brothers</b>		

VS 151-REV. 1/1/68

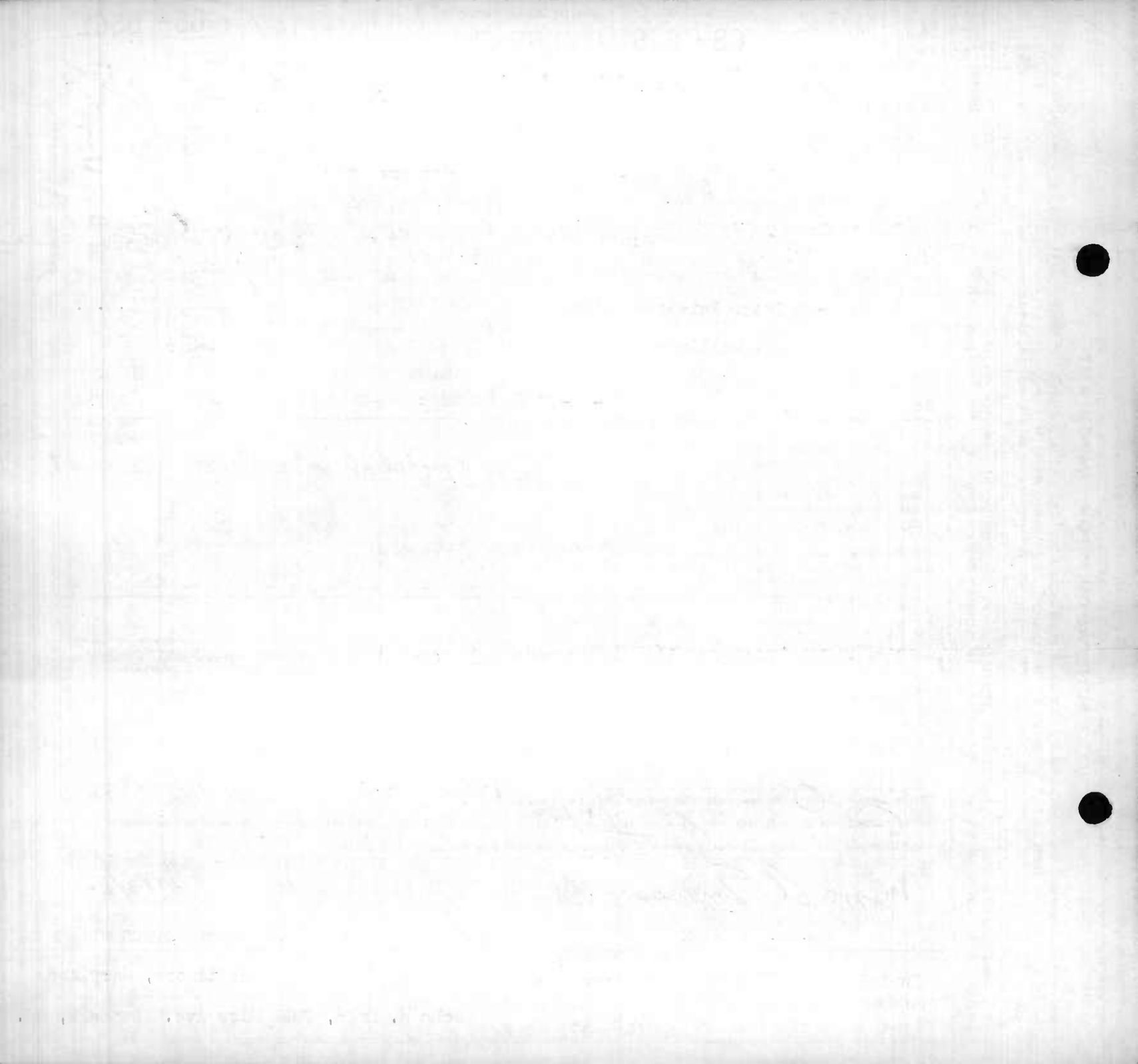
N 869.0



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68- 8361</b>
W-452		68- 8361		CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Carl Wellings</b>		2. DATE AND HOUR OF DEATH <b>8/13/68 7:35 A</b> M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> <b>49440 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND 21224</b>		C. CITY OR TOWN <b>Edgemere Point</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-4-01</b> 9. AGE (In years last birthday) <b>67</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED -Engineer Patapsco Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>GEORGE Wellings</b>		14. MOTHER'S MAIDEN NAME <b>IDA Fisher</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-10-9776</b>		17. INFORMANT <b>RECORDS: BCH-4940 EASTERN AVENUE 21224</b>
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>several hours</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION <b>4-20-01</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>II</b>		
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
22. I certify that (I) (this hospital) attended the deceased from <b>8/13/68 7 AM</b> to <b>8/13/68 7:35 AM</b> 19 <b>68</b> and that (I) (we) last saw the deceased alive on <b>7/13/68</b> 19 <b>68</b> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Wm A. Emerson MD</b>		23B. DATE SIGNED <b>8/13/68</b>		23C. PHYSICIAN'S NAME (Type) <b>WM. A. EMERSON</b>
23D. ADDRESS <b>4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224</b>		23E. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/17/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>
24D. LOCATION <b>Baltimore, Maryland</b>		24E. DATE REC'D BY HEALTH DEPT. <b>AUG 15 1968</b>		
24F. NAME OF REGISTRAR <b>John J. Duda</b>		24G. ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>		



L-525

68- 8362 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8362

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)  
JOHN

David

LONGENECKER

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

August 11, 1968

5:03 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

44 Union Memorial Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

August 11, 1968

5:03 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☒NO ☐

6. SEX

male

7. RACE

white

B. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

Nov. 19, 1901

10. AGE (In years  
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

6305 Dietz Avenue

11. BIRTHPLACE (State or foreign country)

Frederick Co. Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alfred Von Longenecker

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Cabinet Maker

14B. KIND OF BUSINESS OR INDUSTRY

Self Employed

15. MOTHER'S MAIDEN NAME

Sarah Elizabeth Stoner

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

213-18-6885

18. INFORMANT

ADDRESS

Florence V. Longenecker - 6305 Dietz Ave.

19. 412, 41

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

422, 1

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/12/68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

\*-15-68

24C. NAME of CEMETERY or CREMATORY

Gardens of Faith Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 16 1968

25B. NAME OF REGISTRAR

Robert E. Fabela, M.D.

25C. FUNERAL DIRECTOR

John C. Miller Inc-6415 Belair Rd.-21206

ADDRESS

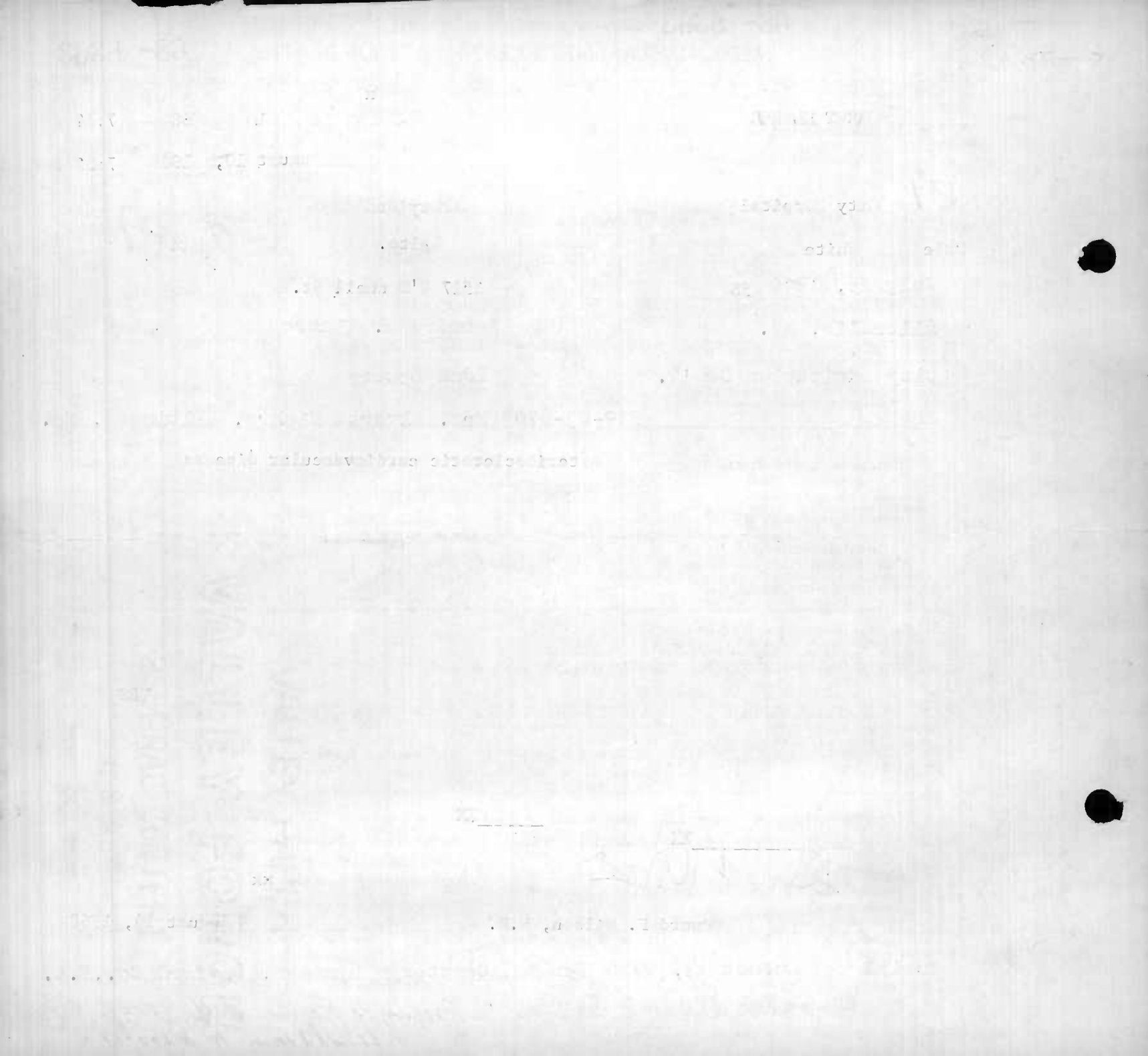


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8363

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ROBERT KLAHRE</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>8 10 68 7:32 a.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>31 City Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 10, 1968 7:32 a.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>July 25, 1910</b>		10. AGE (In years last birthday) <b>58</b>	
11. BIRTHPLACE (State or foreign country) <b>Ellerslie, Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>City Sanitation Dep't.</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Edna Lowery</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>219-03-8703</b>		18. INFORMANT <b>Mrs. Alverta Klahre, Baltimore, Md.</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>422.1</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>8</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>YES</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>August 10, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>August 13, 1968</b>	
24C. NAME of CEMETERY or CREMATORY <b>Hyndman Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Hyndman, Bedford Co., P.a.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 16 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Brunzel Funeral Home</b>		ADDRESS <b>3631 Falls</b> <b>William R. Kleiber</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8364 CERTIFICATE OF DEATH REG. NO. 68- 8364

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Emma S. Helfrich</b>		2. DATE AND HOUR OF DEATH <b>August 13, 1968 11:40 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-11</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE UNION MEMORIAL HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>24 OVERHILL ROAD</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 11, 1892</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>AMERICA</b>		13. FATHER'S NAME <b>THOMAS B. COCKEY</b>		14. MOTHER'S MAIDEN NAME <b>MARY WARFIELD</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-03-7876-D</b>		17. INFORMANT <b>THE CHART</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>RESPIRATORY FAILURE</b>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CEREBRAL HEMORRHAGE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ABOUT 60 HRS</b>	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>422.1 II NONE</b>		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
23. DATE OF OPERATION <b>0</b>		24. CONDITION FOR WHICH OPERATION WAS PERFORMED		25. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
29. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		30. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		31. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 11 1968</b> to <b>AUGUST 13 1968</b> , that (I) (we) last saw the deceased alive on <b>AUGUST 13 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <b>did not</b> view the body after death.					
23A. SIGNATURE <b>Chun Kee Ryu</b>		M.D. <b>M.D.</b> DEGREE		23B. DATE SIGNED <b>AUGUST 14, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>CHUN KEE RYU MD.</b>		23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug 16, 1968</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Thomas Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Garrison Forest, Md.</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 16 1968</b>		25B. NAME OF REGISTRAR <b>Chun K. Ryu</b>	
25C. FUNERAL DIRECTOR <b>Newell Funeral Home</b>		25D. ADDRESS <b>2509 N. ...</b>			



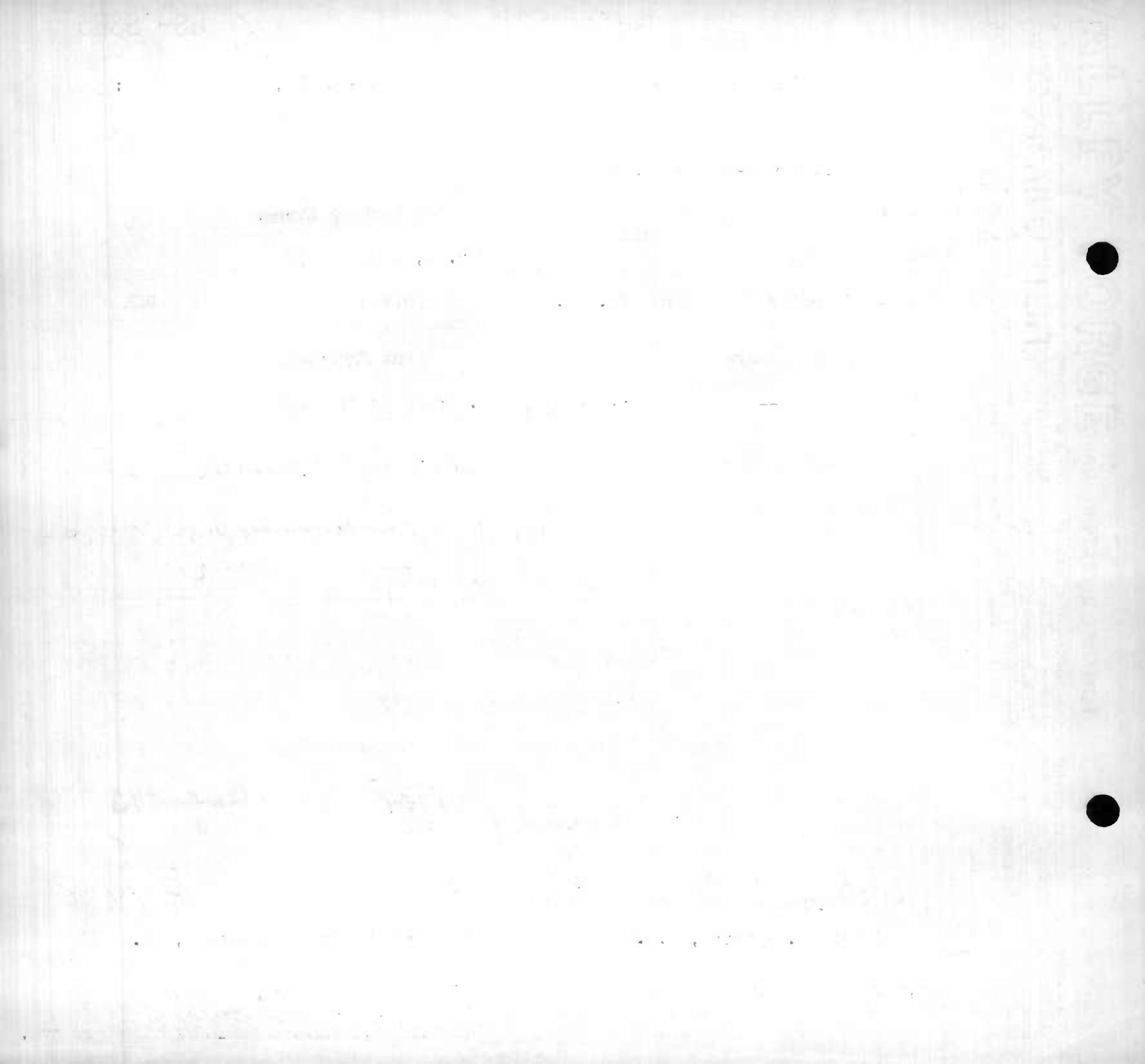
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8365 CERTIFICATE OF DEATH

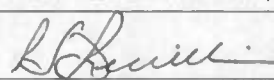
REG. NO. 68- 8365

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ANTOINETTE GROSZKOWSKI</b>		2. DATE AND HOUR OF DEATH <b>August 13, 1968</b>   <b>7:35 AM</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore Co.</b>		53-00	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b>		C. CITY OR TOWN <b>Essex (21)</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
31		E. STREET AND NUMBER <b>341 Homberg Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>Cau</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 17, 1910</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Shoe Mfg. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Anthony Redyk</b>		14. MOTHER'S MAIDEN NAME <b>Anna Frydryczyk</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213 14 0217</b>		17. INFORMANT <b>I. Frank Groszkowski</b> Same	
18. <b>277X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Occlusion</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertensive Cardiovascular Heart disease</b> (B) <b>ability</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>years</b> <b>1</b>	
MEDICAL CERTIFICATION <b>287X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1938</b> 19 to <b>August 13</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>August 9</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William L. Fearing, M.D.</b>				23B. DATE SIGNED <b>8-14-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>William L. Fearing, M.D.</b>		23D. ADDRESS <b>3025 Belair Road Baltimore, Md. 21213</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/16/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Rosary Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. FUNERAL DIRECTOR <b>Bruzdinski Funeral Home</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 16 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fearing</b>		25C. ADDRESS <b>1407 Eastern Ave.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="border: 1px solid black; padding: 2px;">X</span>	68- 8366
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HARP, -HELEN Loretta		AUGUST 14, 1968 10:50A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  40 ST. AGNES HOSPITAL			A. STATE MARYLAND B. COUNTY AA 52-00		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER 1210 BEACH PROMANADE 21226		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06/27/03	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			11. BIRTHPLACE (State or foreign country) OHIO (Cleveland)		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ? Keller			14. MOTHER'S MAIDEN NAME CARRIE MC DOWELL <del>KELLER</del>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS
18. <u>250.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH ACUTE MYOCARDIAL INFARCTION (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  DIABETES MELLITUS (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>260X II</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 13</u> 19 <u>68</u> to <u>AUGUST 14</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>AUGUST 14</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) DEGREE
23D. ADDRESS BALTIMORE, MD. 21229 ST. AGNES HOSP; CATON & WILKENS AVES. DEGREE			23E. FUNERAL DIRECTOR ADDRESS Woodlawn, Md. Balto. Co.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/22/68		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery	
24D. LOCATION (City, town, or county) (State) Woodlawn, Md. Balto. Co.		24E. DATE REC'D BY HEALTH DEPT. AUG 16 1968		24F. NAME OF REGISTRAR Robert E. Sullivan	
24G. FUNERAL DIRECTOR ADDRESS Woodlawn, Md. Balto. Co.		24H. DATE REC'D BY HEALTH DEPT. AUG 16 1968		24I. NAME OF REGISTRAR Robert E. Sullivan	

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68- 8367 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8367

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOHN GREGORY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>August 13, 1968</b> Hour <b>12:30 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1828 Wilkens Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 13, 1968 6:35 A.M.</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>May 2, 1925</b>		10. AGE (In years last birthday) <b>43</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna</b>		12. CITIZEN OF WHAT COUNTRY? <b>Ralph Gregory</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction worker</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Reiley Funeral Home York, Pa.</b>		ADDRESS	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>No</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>8/13/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/17/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>St. Mary's Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>York, Pa.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 16 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Ullrich Funeral Home</b>		ADDRESS <b>4210 Belair Road, for Reiley Funeral Home, York, Pa.</b>	

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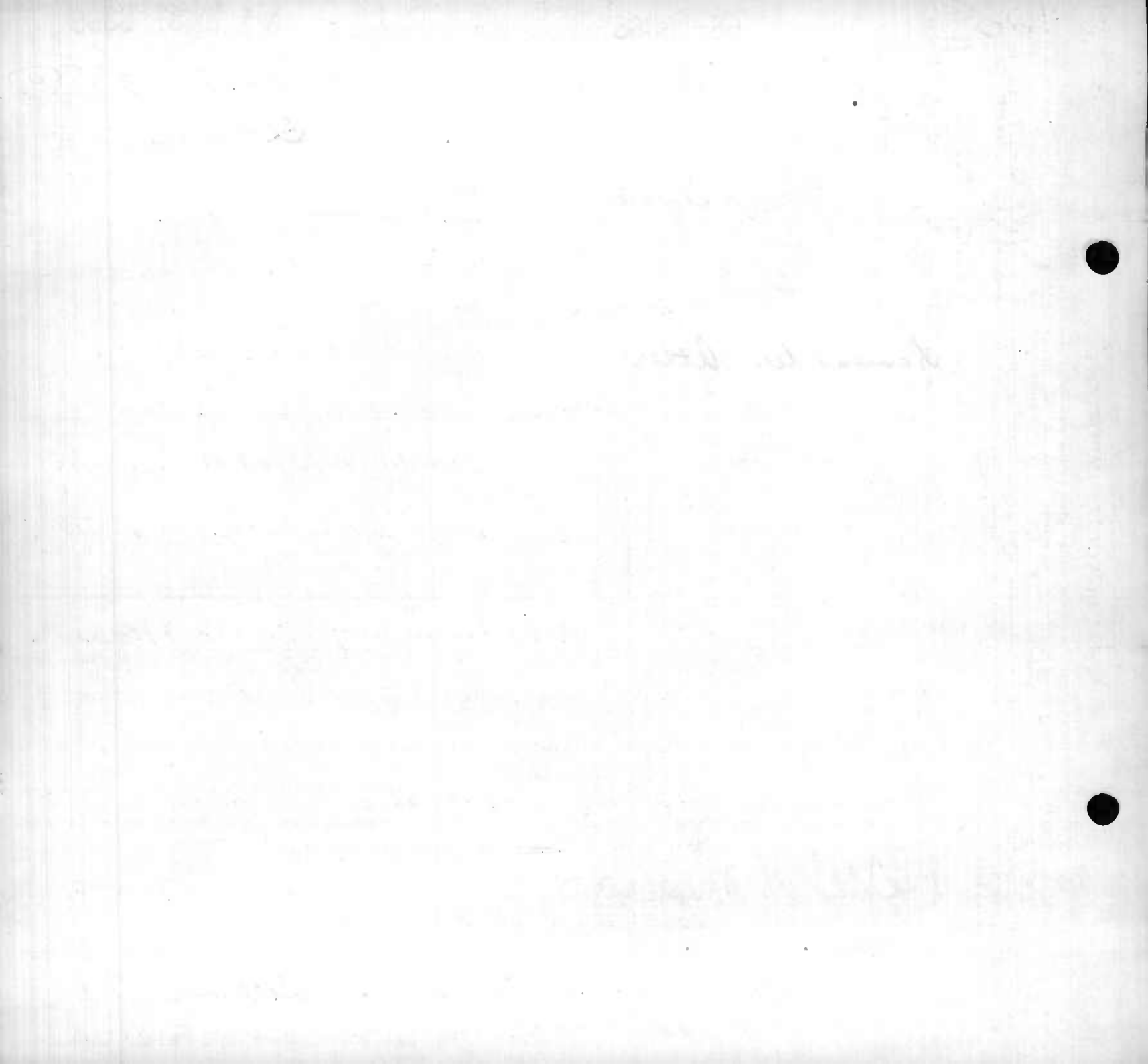
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8368 CERTIFICATE OF DEATH

REG. NO. 68- 8368

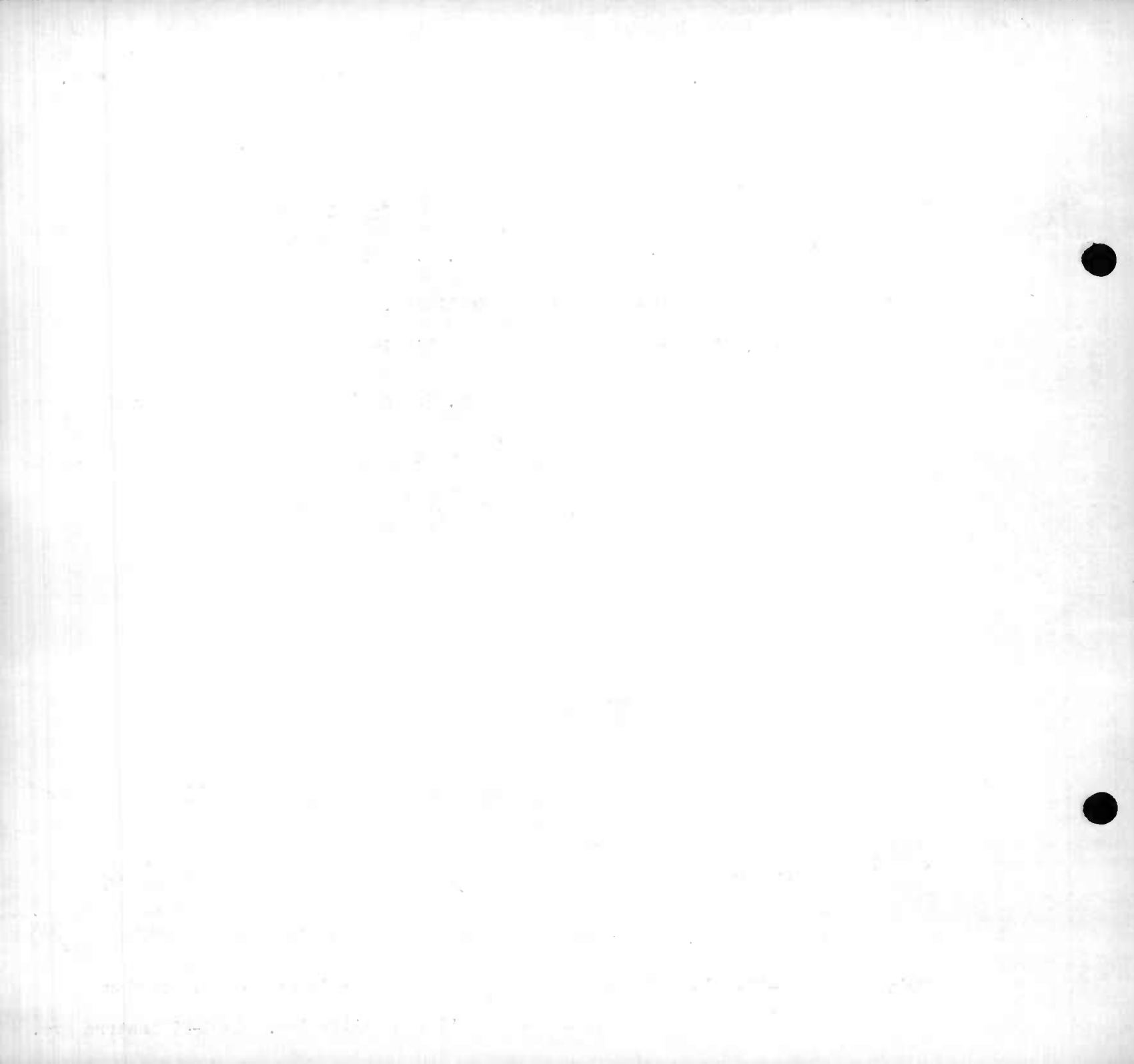
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Theodore Black</i>		2. DATE AND HOUR OF DEATH <i>8-13-68 3:55 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore Co.</i> <i>53-00</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>1204 Tupelo Place</i>	
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/29/18</i>	9. AGE (In years last birthday) <i>50</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>US Government</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	
13. FATHER'S NAME <i>Lauren W. Adler</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth (last name unknown)</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW II</i>		16. SOCIAL SECURITY NO. <i>212-16-8034</i>		17. INFORMANT <i>Thomas W. Black</i> ADDRESS <i>1204 Tupelo Place</i>	
18. <i>410.9 I</i> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>A.S.C.H.D. Suggestive of MI</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <i>Extensive Coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF		<i>months</i>
(C) _____					
19. <i>420.1 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Obstructive air way disease (severe) years</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (netely medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8-12-68</i> 19 <i>68</i> to <i>8-13</i> 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>8-13</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <i>Philip H. Moore MD.</i>				23B. DATE SIGNED <i>8-14-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Philip H. Moore MD.</i>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>8/16/68</i>		24C. NAME of CEMETERY or CREMATORY <i>Sacred Heart Cemetery of Jesus</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 16 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Fickens</i>		25C. FUNERAL DIRECTOR <i>Lassahn Funeral Home 7401 Belair Road</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

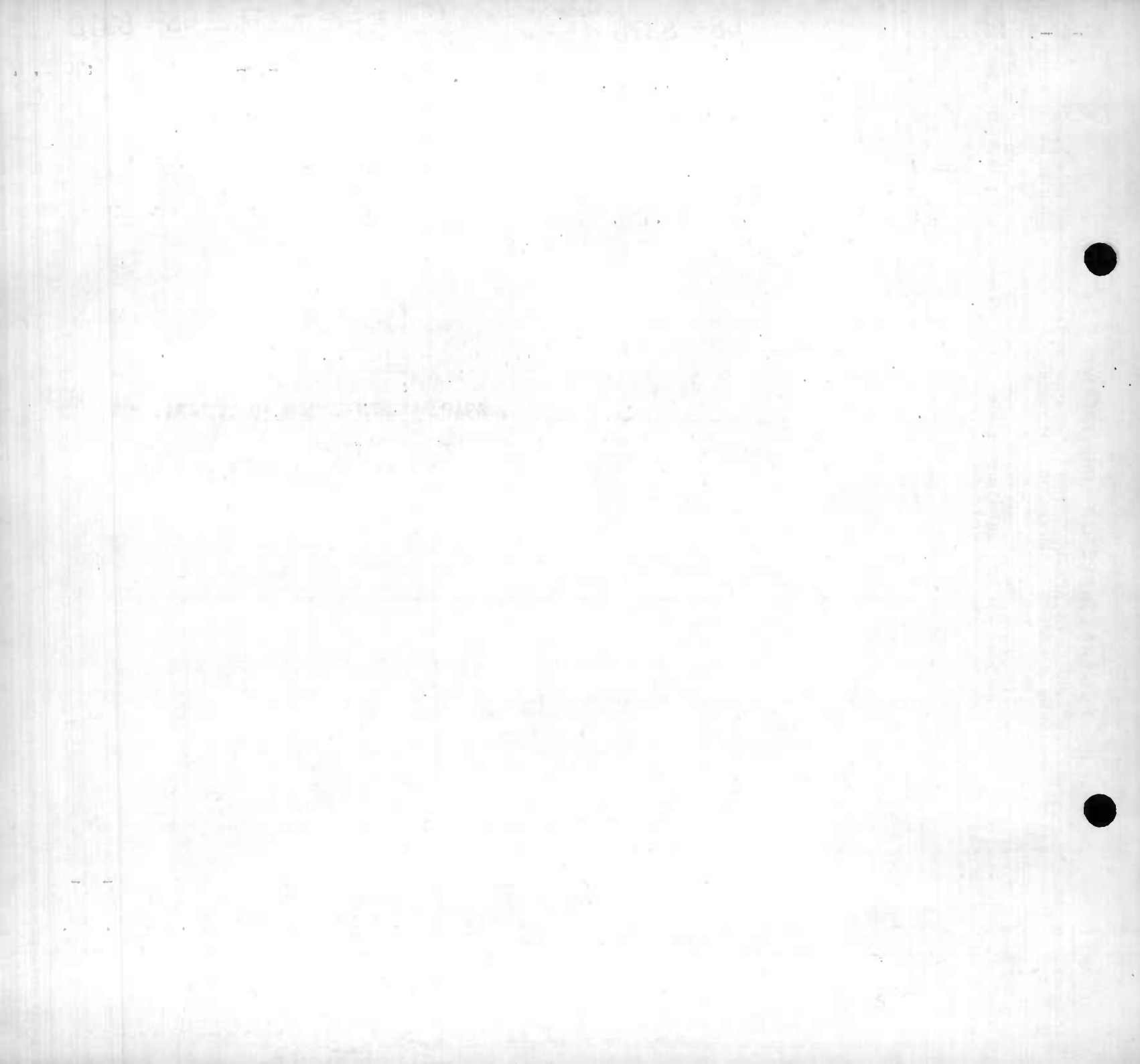
BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
M.E. CASE NO.				68- 8369		68- 8369	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
JOHN M. AICHLER				August 15, 1968		1:05 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
00 903 Fell Street				Maryland			
				C. CITY OR TOWN (If outside city limits, give RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				903 Fell Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months	11. UNDER 24 Hrs. Days	12. CITIZEN OF WHAT COUNTRY?
Male	White	Married	Aug. 4, 1911	57			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Machinest		Maryland Drydock		Baltimore, Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John M. Aichler				Minnie Krouse			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
						Mrs. Helen Aichler 903 Fell Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) DUE TO		Approx 6-8 mo	
				(B) DUE TO			
				(C) DUE TO			
163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
D							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/7 MARCH 30 1968 to 8/15 1968, that (I) (we) last saw the deceased alive on 8/7 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
22A. SIGNATURE				22B. DATE SIGNED			
Irvin B. Kaplan				8/16/68			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Irvin B. Kaplan M.D.				129 S. Broadway BALTO MD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8-19-1968		Sacred Heart		Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 16 1968		Robert E. Fisher, Jr.		Lilly & Zeiler Inc.		1901-07 Eastern Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

42-40-31 LB		H-400 68-8370		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-8370	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HOEHL, FREDERICK J.</b>		2. DATE AND HOUR OF DEATH <b>8-13-68 6:30 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>7-02</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITAL</b> <b>4940 EASTERN AVE., BALTO., MD. 21224</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-5-03</b>	
9. AGE (In years last birthday) <b>65</b>		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BAKER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
13. FATHER'S NAME <b>OTTO HOEHL</b>				14. MOTHER'S MAIDEN NAME <b>BARBARA HOFFMAN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNK</b>		16. SOCIAL SECURITY NO. <b>212-70-6852</b>		17. RECORDS ADDRESS <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224</b>			
18. I <b>3-83 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>A. HEPATIC COMA</b> <b>B. HEPATO RENAL FAILURE</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>C.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>4 days</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>8-13-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NONE</b>		21C. WHERE DID INJURY OCCUR? <b>NA</b>		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) <b>N-A.</b>		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/> <b>NA</b>		21F. HOW DID INJURY OCCUR? <b>NA</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>7-9-1968</b> to <b>8-13-1968</b> , that (I) (we) last saw the deceased alive on <b>8-13-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
22A. SIGNATURE <b>Bruce M. Bucher M.D.</b>				23B. DATE SIGNED <b>8/13/68</b>			
23C. PHYSICIAN'S NAME (Type) <b>BRUCE M. BUCHER M.D.</b>		23D. ADDRESS <b>BCH 4940 EASTERN AVE., BALTO., MD. 21224</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-17-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>HOLY REDEEMER CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO., MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 16 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Feltner</b>		25C. FUNERAL DIRECTOR <b>Stanley Miller</b>		ADDRESS <b>2334 Jefferson St.</b>	



68- 8371

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8371

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>GLORIA JONES</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>August 8, 1968</b> Hour <b>10:00 A.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 2201 Eutaw Place</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>August 8, 1968</b> Hour <b>10:00 A.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>2/22/46</b>		10. AGE (In years last birthday) <b>23</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>JAMES Wiggins</b>		14. MOTHER'S MAIDEN NAME <b>Julia Beck</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>William H. Jones</b> ADDRESS <b>Balt. Md.</b>	
19. <b>303.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Acute Ethylism</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>322.0 II Acute Pyelonephritis</b>			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/15/68</b>	
24C. NAME of CEMETERY or CREMATORY <b>MC. AUBURN</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 16 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>	
25C. FUNERAL DIRECTOR <b>J.B. Johnson</b>		ADDRESS <b>1900 Eutaw Pl. Balt. Md.</b>	

62-835

62-835

1

\*

Baltimore, Md. USA  
 Domestic  
 James Wiggins  
 John Back  
 William H Jones  
 Baltimore, Md

Bureau of Civil Liberties  
 Baltimore, Md.  
 18. Johnson 1900 Estate

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8372	
T-620 68- 8372				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		M.	
Torres, Benny (Benedetto)		Aug 14 1968			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
(If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Maryland		Baltimore Co. 53-00			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Mixologist (Retired) Club				Italy	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Joseph Torres		Gerra		America	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
unknown		213-34-5645		Son 5521 Forest Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		Cerebral Vascular Accident			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Senile arteriosclerosis			
		(C) Heart enlargement			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
331 X		II		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 7-13 1968 to 8-14 1968, that (I) (we) lost saw the deceased alive on 8-14 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Benito Martinez				8-14-68	
23C. PHYSICIAN'S NAME (Typed)				23D. ADDRESS	
Benito Martinez				BON SECOURS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/19/68		New Cathedral Cemetery	
24D. LOCATION (City, town, or county)		24E. STATE		24F. ADDRESS	
Baltimore, Md.				Witzke Funeral Dir., 4101 Edmondson 21229	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 18 1968		A. E. J. Smith		Witzke Funeral Dir., 4101 Edmondson 21229	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 8373	
1. NAME OF DECEASED (Type or Print) <b>Flora Thomas, (FLORIDA) E.</b>		2. DATE AND HOUR OF DEATH <b>8/15/68 6.30 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>36 FRANKLIN SQUARE Hospt.</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>805 FULTON AVE.</b>			
5. SEX <b>F</b>	6. RACE <b>N.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/14/1902</b>	9. AGE (In years last birthday) <b>66</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>		13. FATHER'S NAME <b>BENJAMIN EDGE.</b>		14. MOTHER'S MAIDEN NAME <b>AMELIA HOLDEN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>HATTIE M. SWEETS 506 N. GILMORE AVE.</b>	
18. <b>436.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIAC ARREST</b> (B) <b>CVA. Hypertension (Pneumonia)</b> (C)			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>331X II</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/6</b> 19 <b>68</b> to <b>8/15</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/15</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <b>Chul On Kwon MD.</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Chul On Kwon MD.</b>				23D. ADDRESS <b>FRANKLIN SQUARE Hospt.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/20/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Not Auburn</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 16 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Thomas Phyllis B. Nigh</b>		ADDRESS	

RECEIVED

BENJAMIN EBBE

1800

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AMELIA HOLDEN

1800

2/14/18

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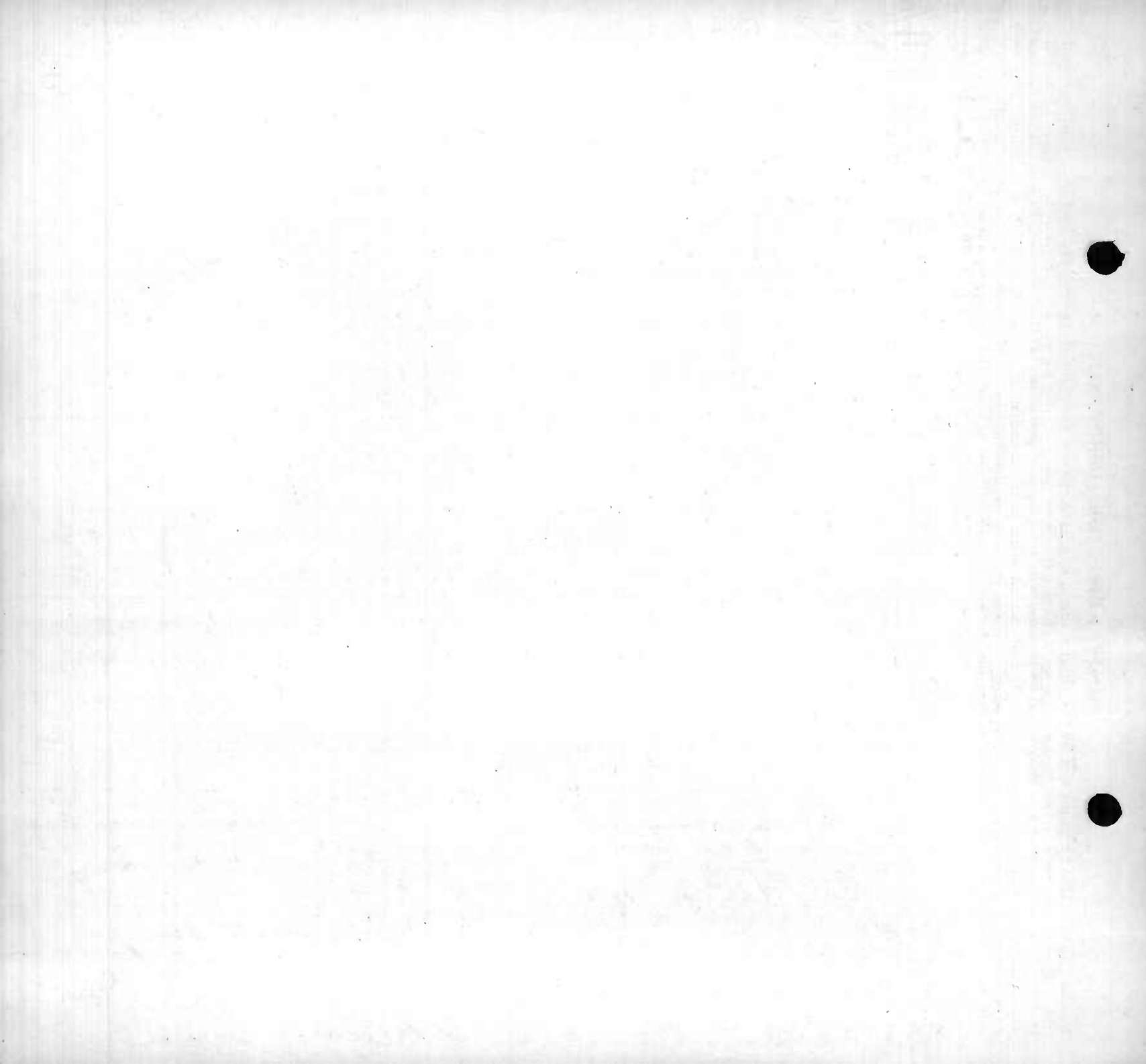
2/14/18

2/14/18

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

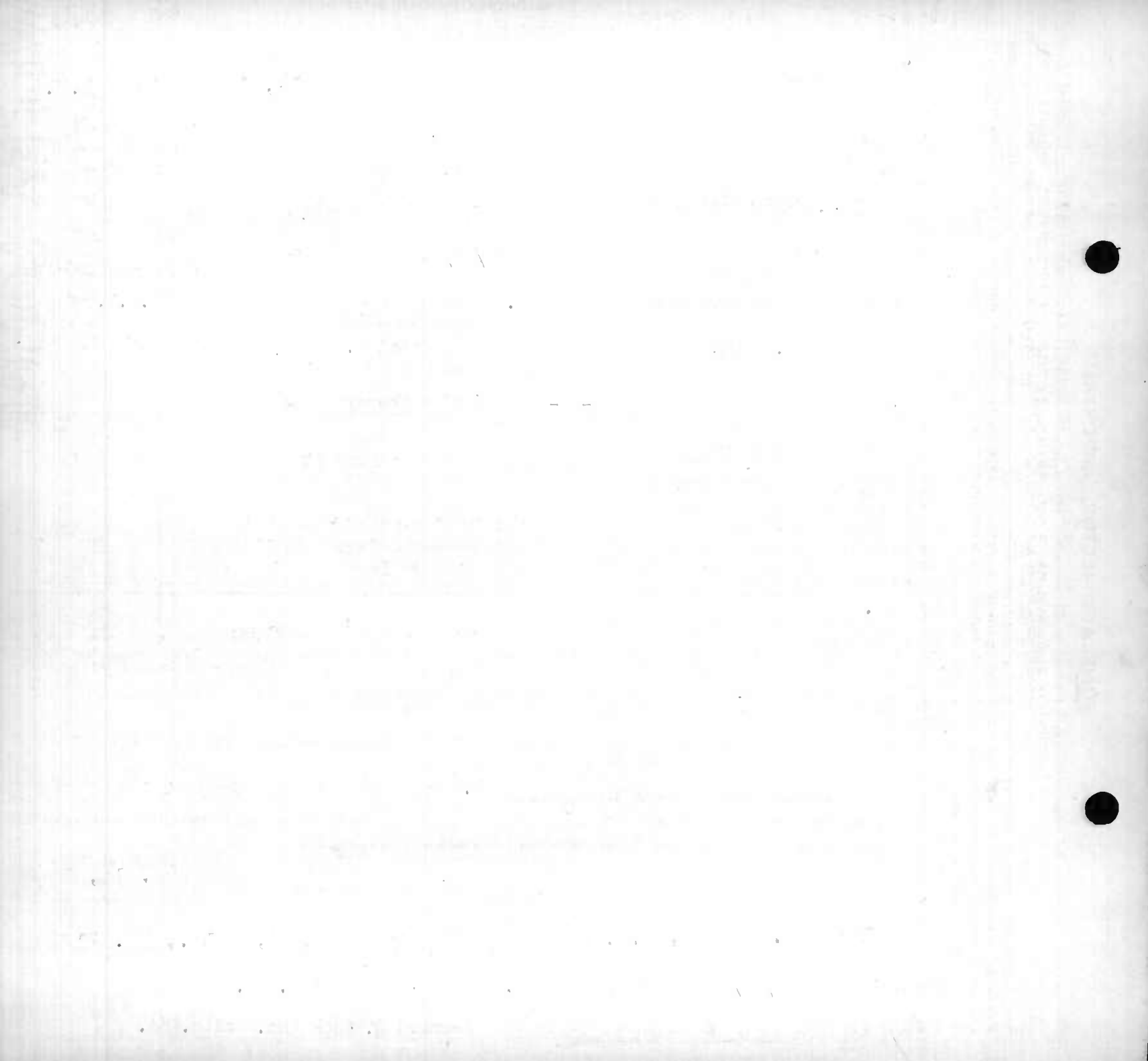
Baltimore City Health Department				REG. NO. 68-8374
<div style="display: flex; justify-content: space-between;"> <span>H-252 68-8374</span> <span>CERTIFICATE OF DEATH</span> </div>				
BIRTH NO.				
1. NAME OF DECEASED (Type or Print) <i>Geneveive Hawkins</i>		2. DATE AND HOUR OF DEATH <i>8/9/68</i> <i>7:05</i> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>md</i> B. COUNTY <i>Charles Co.</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>George Washington Nursing Home</i> <i>607 Pennsylvania ave</i> <i>BALT. md. 21201</i>		C. CITY OR TOWN <i>Fac/Kover</i>	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Female</i>	6. RACE <i>Amer. Negre</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 30, 1902</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>66</i>	
11. BIRTHPLACE (State or foreign country) <i>Bryantown md. Charles County</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>216-16-0074</i>	17. INFORMANT <i>Chart</i>	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Art. Inf. Cardio Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Genet. Defect. Arterio Sclerosis</i>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 hrs.</i>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <i>420.1 II</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <i>5/19/68</i> 19 <i>66</i> to <i>8/9/68</i> 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>8/8</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>E E Holt md</i>		23B. DATE SIGNED <i>8/9/68</i>		
23C. PHYSICIAN'S NAME (Type) <i>Edward E. Holt</i>		23D. ADDRESS <i>3715 Liberty Height Ave.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)	
<i>8/19/68 Burial</i>	<i>8/19/68</i>	<i>M. Calvary</i>	<i>Glas. Burman Md.</i>	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS	
<i>AUG 16 1968</i>	<i>Robert E. Fulkerson</i>	<i>J. P. Carroll Funeral Home</i>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

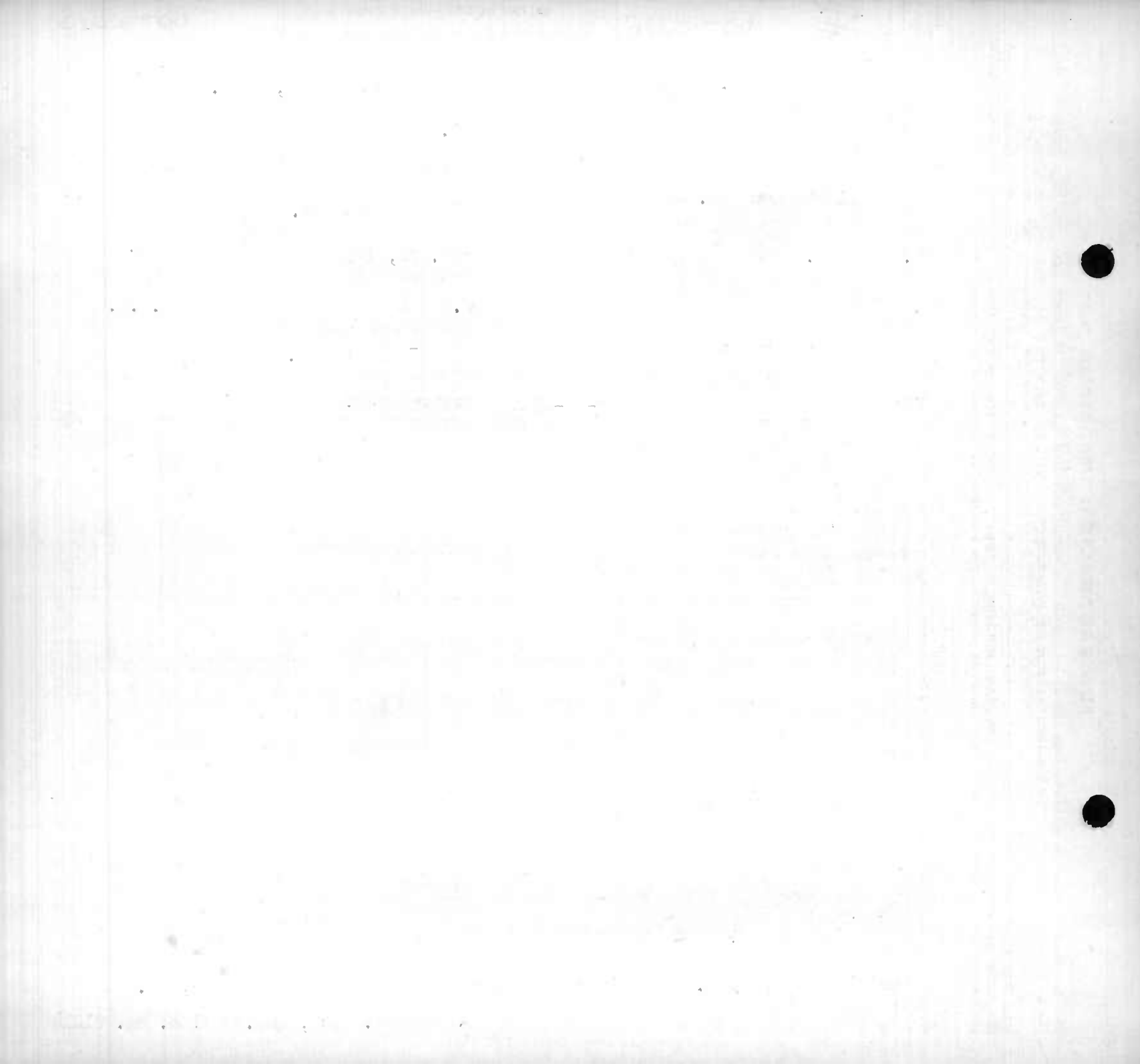
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8375	
<div style="display: flex; justify-content: space-between;"> <span>K-500</span> <span>68- 8375</span> <span>CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print) <b>Daniel V. Kenney</b>			2. DATE AND HOUR OF DEATH <b>August 14, 1968 12:45 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1 E. University Parkway</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1 E. University Parkway</b>		
5. SEX <b>M.</b>	6. RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/21/39</b>	9. AGE (In years last birthday) <b>29</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Director of Personnel</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Shepard Pratt Hosp.</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Daniel H. Kenney</b>		
14. MOTHER'S MAIDEN NAME <b>Estel B. Karch</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO. <b>292-34-2996</b>			17. INFORMANT ADDRESS <b>Sandra Kenney same</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrest</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic Pyelonephritis with Renal Failure</b>			20. DUE TO, OR AS A CONSEQUENCE OF: <b>9 months</b>		
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Chronic Sacral Decubitus Ulcer</b>			22. DUE TO, OR AS A CONSEQUENCE OF: <b>9 months</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>Oct. 23 1968</b> to <b>August 14 1968</b> , that (I) (we) last saw the deceased alive on <b>August 12 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William G. Esmond, M.D.</b>			23B. DATE SIGNED <b>Aug. 15, 1968</b>		23C. PHYSICIAN'S NAME (Type) <b>William G. Esmond, M.D.</b>
23D. ADDRESS <b>537 Stamford Road, Balt., Md. 21229</b>			24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		
24B. DATE <b>8/16/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Greenmount Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 16 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck Inc. Balto. Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-355 68- 8376				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 8376	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Catherine M. Huthman		2. DATE AND HOUR OF DEATH August 15, 1968. 4:10 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 5321 Grindon Ave.				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5321 Grindon Ave.			
5. SEX F.	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1890		9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Kampes			14. MOTHER'S MAIDEN NAME - Anna M. Aul				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 218-05-9341		17. INFORMANT Margaret Schuman same		ADDRESS
18. 440.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Generalized Arteriosclerosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 450.0 II							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Mar. 1967 to August 1968, that (I) (we) last saw the deceased alive on August 13, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Loy M. Zimmerman M.D.				23B. DATE SIGNED 8/15/68			
23C. PHYSICIAN'S NAME (Type) Loy M. Zimmerman M.D.				23D. ADDRESS 3202 Hanford Rd Baltimore, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/17/68.		24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1968		25B. NAME OF REGISTRAR Robert E. Sullivan		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. B alto. Md. 21214			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										REG. NO. 68- 8377	
U-452 68- 8377										CERTIFICATE OF DEATH	
BIRTH NO.										105 P.M.	
1. NAME OF DECEASED (Type or Print) Williams, Arthur J.					2. DATE AND HOUR OF DEATH 8/14/68						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY						
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital					2631 N. Hillton St. C. CITY OR TOWN Baltimore, Md.					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M					6. RACE N N					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 11-27-10					9. AGE (In years last birthday) 57					If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter					10B. KIND OF BUSINESS OR INDUSTRY Westinghouse					11. BIRTHPLACE (State or foreign country) Arbutus, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME Arthur W. Williams					14. MOTHER'S MAIDEN NAME Nellie	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 218-01-4884					17. INFORMANT Mrs. Dorothy Williams	
18. 5-27-18 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH					ADDRESS 2631 N. Hillton	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute gastro intestinal bleeding					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour	
ANTECEDENT CAUSES					(B) DUE TO, OR AS A CONSEQUENCE OF: Portal hypertension + ascites					2 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) Nutritional Cirrhosis					3 yrs.	
3-8-1-0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED					21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 8, 1968 to August 14, 1968, that (I) (we) last saw the deceased alive on August 14, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Howard R. Friedman M.D.					23B. DATE SIGNED 8/14/68						
23C. PHYSICIAN'S NAME (Type) Howard R. Friedman M.D.					23D. ADDRESS Sinai Hospital of Baltimore, Md.						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 8-17-68					24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION Arbutus					24E. ADDRESS 1701 Laurens						
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1968					25B. NAME OF REGISTRAR Robert E. [unclear]					25C. FUNERAL DIRECTOR Morton E. Dyett F.H.	

For service of 100

22 00

1 day of school

11/11/11

1 day of school

11/11/11

11/11/11

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <i>M-200 68-8378</i>				Baltimore CITY HEALTH DEPARTMENT		REG. NO. <i>68-8378</i>	
1. NAME OF DECEASED (Type or Print) <i>McCoy ELIZABETH.</i>				2. DATE AND HOUR OF DEATH <i>8-13-68 9:20 a.m.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>BALTIMORE CITY HOSPITALS.</i> <i>4940 EASTERN AVENUE</i> <i>BALTIMORE, MARYLAND 21224</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i> 6. RACE <i>N</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				B. DATE OF BIRTH <i>12-20-1910</i>		9. AGE (In years last birthday) <i>57</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>SOUTH CAROLINA</i>	
13. FATHER'S NAME <i>EDWARD Brisbane</i>				14. MOTHER'S MAIDEN NAME <i>SALLY. Brisbane</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>BCH RECORDS: 4940 EASTERN AVENUE 21224</i>	
18. <i>250.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>DIABETIC ACIDOSIS</i> (B) <i>URINARY TRACT INFECTION</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hours</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>260x II</i>				<i>CRONIC BRAIN SYNDROME &amp; VASCULAR INSUFFICIENCY.</i>			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>X</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>X</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>X</i>			
21D. TIME OF INJURY (APPROX.) <i>X</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>7-30-1968</i> to <i>8-13-1968</i> , that (I) (we) last saw the deceased alive on <i>8-13-1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>S. C. Schar M.D.</i>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8-13-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR. S. C. SEKAR</i>				23D. ADDRESS <i>BALTIMORE CITY HOSPITALS - EXT 669</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-17-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 16 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Morton E. Dyett F.H.</i>		ADDRESS <i>1701 Laurens</i>	



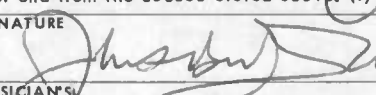
# FUNERAL DIRECTOR: IMPORTANT

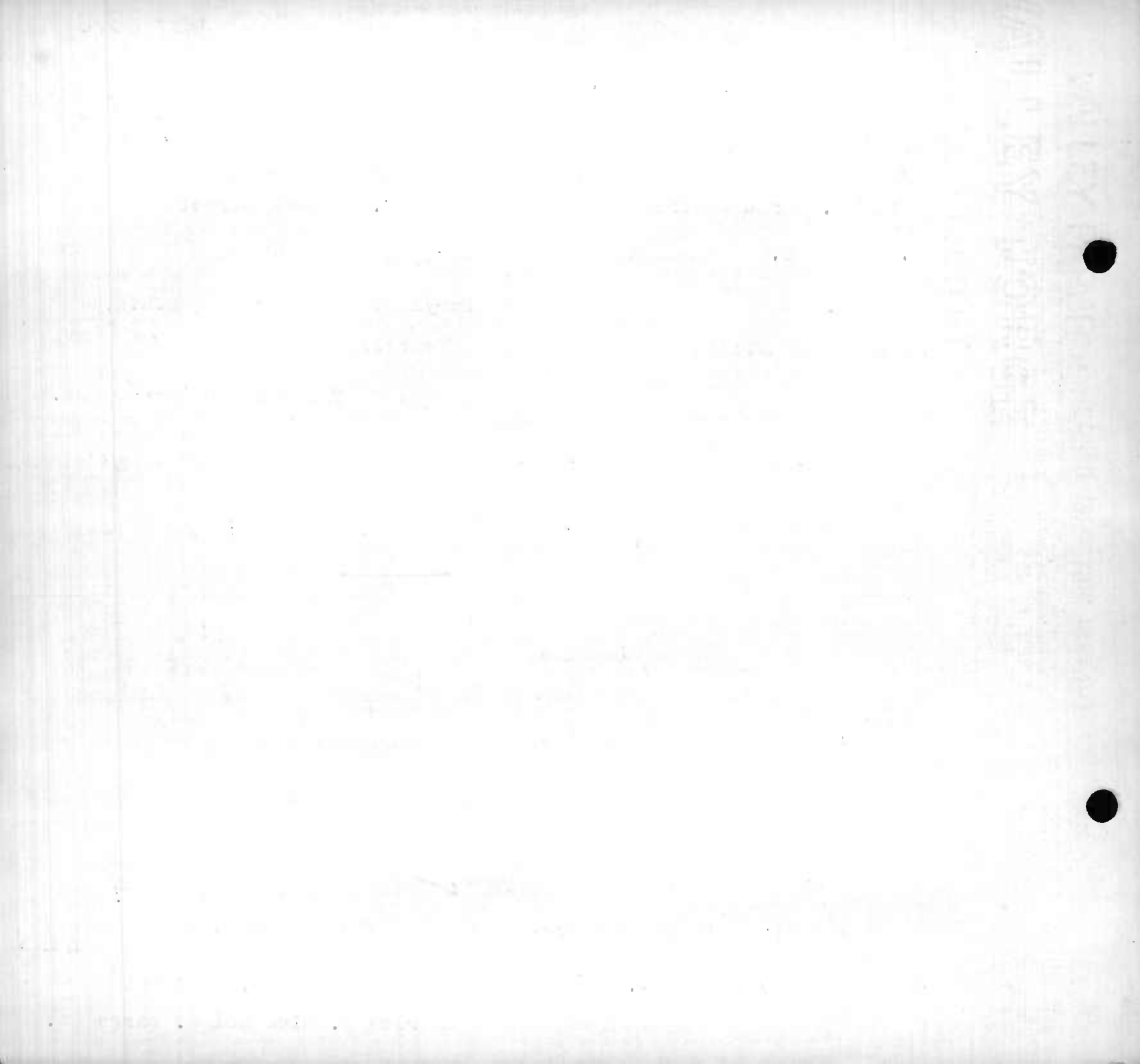
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## 68- 8379 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68- 8379

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Gertrude W. Lee		8/9/68	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION  00 758 W. Hamburg Street				A. STATE Maryland	
				B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 758 W. Hamburg Street	
5. SEX F.	6. RACE C.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/30/89		9. AGE (In years last birthday) 78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Wesley Williams				14. MOTHER'S MAIDEN NAME Isabelle	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT George Williams	
				ADDRESS 758 Hamburg St.	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
CAUSE OF DEATH MYOCARDIAL INFARCTION (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  ARTERIOSCLEROTIC C-V DIS (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/2/1968 to 8/9/1968, that (I) (we) last saw the deceased alive on 8/3/1968 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 8/9/68	
23C. PHYSICIAN'S NAME (Type) JOHN S. BRAXTON JR.				23D. ADDRESS 612 Hillview Rd, Balt, Md 21225	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/13/68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT AUG 16 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Charles A. Rice	
				ADDRESS 661 W. Barre St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 8380	
1. NAME OF DECEASED (Type or Print) <b>MARGARET E. HARDING</b>			2. DATE AND HOUR OF DEATH <b>8-15-68</b> <b>1:10 A. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland #21224</b>			A. STATE <b>Maryland</b> B. COUNTY <b>18-01</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>518 North Fremont Avenue #21202</b>		
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>10/19/22</b>	9. AGE (In years lost birthday) <b>45</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Johnson (dec.)</b>			14. MOTHER'S MAIDEN NAME <b>Ethel (dec.) Aug 1</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>BCH Records: 4940 Eastern Avenue</b> <b>Baltimore, Maryland #21224</b>		
18. <b>011.7</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>PNEUMONIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>PULMONARY TUBERCULOSIS</b> <b>CIRRHOSIS OF LIVER</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>002.1 II</b> <b>CIRRHOSIS OF LIVER</b>					
19A. DATE OF OPERATION <b>8-13-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>INTEST. OBST.</b>	20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7/18</b> <b>19 68</b> to <b>8/15</b> <b>19 68</b> , that (I) (we) last saw the deceased alive on <b>8/15</b> <b>19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William E. Powers, M.D.</b>				23B. DATE SIGNED <b>8/15/68</b>	
23C. PHYSICIAN'S NAME <b>WILLIAM E. POWERS, M.D.</b>		23D. ADDRESS <b>BCH: 4940 Eastern Avenue</b> <b>Baltimore, Maryland #21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/19/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memoria / R. Arbutus Mt.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 16 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>Williams Funeral Home 319 N. Howard St.</b>			



FUNERAL DIRECTOR: IMPORTANT

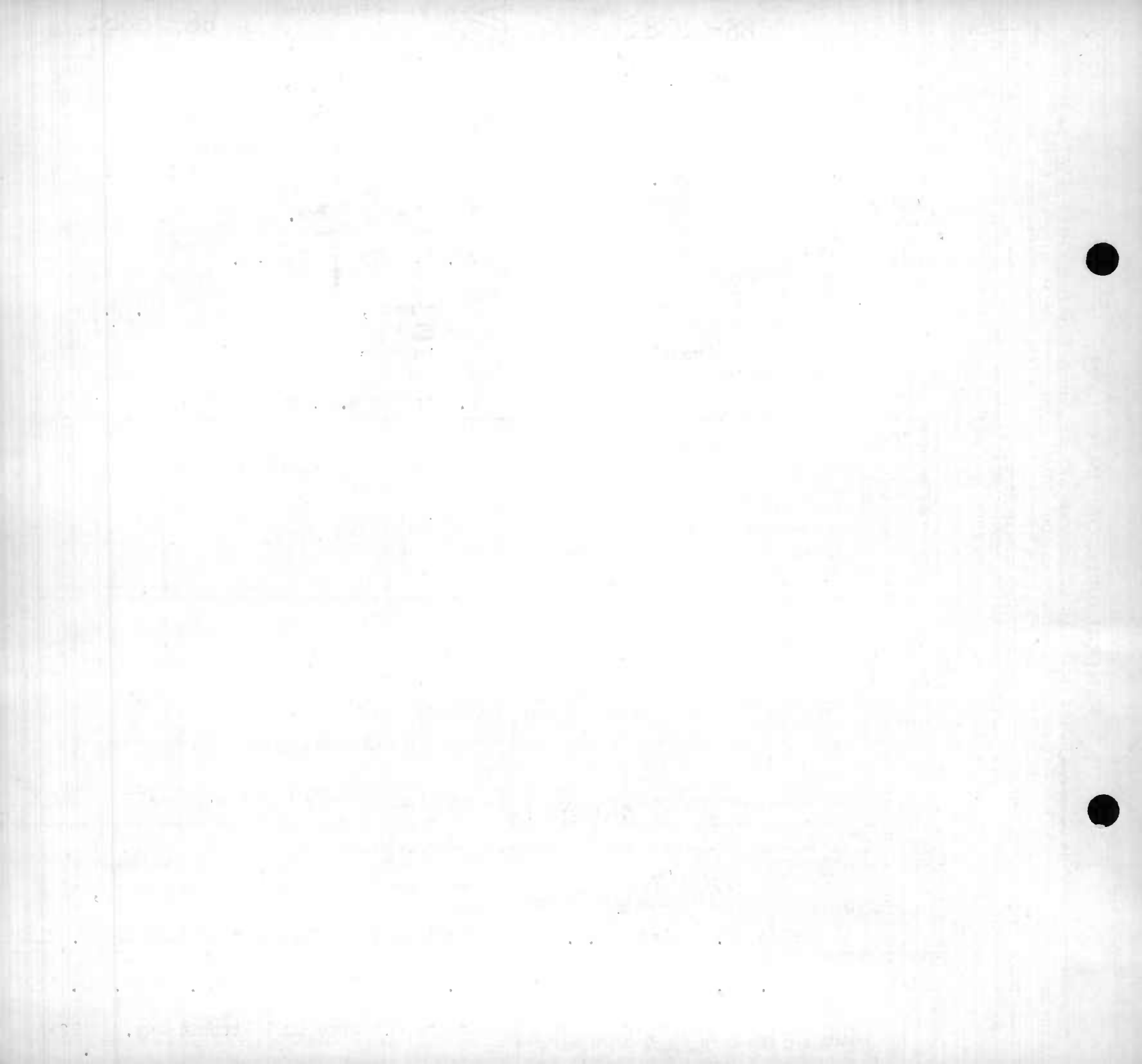
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8381

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 8381

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HELEN CECILIA KNOX		August 10, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 00 3958 Brooklyn Ave.				A. STATE Maryland	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3958 Brooklyn Ave.	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. If Under 1 Yr. Months Days
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 4, 1893	74 yrs.	11. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		None		Baltimore, Maryland	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Buchal			U. S.		
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service)		
Unknown			No		
16. SOCIAL SECURITY NO.			17. INFORMANT		
			Mr. Stanley A. Knox		
			ADDRESS		
			Same		
18. 410.9 I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
acute myocardial infarction					
ASCVD -					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
420.1 II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from March 19 67 to August 19 68, that (I) (we) last saw the deceased alive on August 10 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Ewald H. Weiss M.D.				August 12, 1968	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				Medical Center 615 Hammonds Land Balto. 21225	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		Aug. 14, 1968		New Cathedral Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 16 1968		R. E. S. Taylor		George J. Gonce 4001 Ritchie Hwy. (21225)	
				ADDRESS	



68- 8382

BALTIMORE CITY HEALTH DEPARTMENT

68- 8382

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

HELEN

P.

KLOCZEWSKI

2. DATE  
OF  
DEATHKnown ☒  
Estimated ☐

Month

Day

Year

Hour

August 12, 1968

1:25 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

85 Church Home Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

August 12, 1968

1:25 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

female

7. RACE

white

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS

YES ☒ NO ☐

9. DATE OF BIRTH

Sept. 1, 1919

10. AGE (In years  
lost birthday)

49

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

400 N. Kenwood Avenue

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Henry Powers

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Waitress

14B. KIND OF BUSINESS OR INDUSTRY

Restaurant

15. MOTHER'S MAIDEN NAME

---- Gardner

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

256-22-8779

18. INFORMANT

ADDRESS

Mrs. Otis Pate - 4202 Bell Grove Rd

19.

571.9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Cirrhosis of Liver

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

581.0 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

0

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/12/68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8-15-1968

24C. NAME of CEMETERY or CREMATORY

Beaver Creek Ch. Cemetery

24D. LOCATION (City, town, or county) (State)

Heath Springs, Rock Hill, S. C.

25A. DATE REC'D BY HEALTH DEPT.

AUG 16 1968

25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

George J. Gonce, 4001 Ritchie Hgwy., Balti-

ADDRESS

WILLIAM J. HARRIS

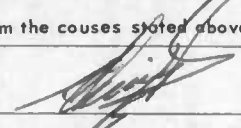
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

## 68- 8383 CERTIFICATE OF DEATH

REG. NO. 68- 8383

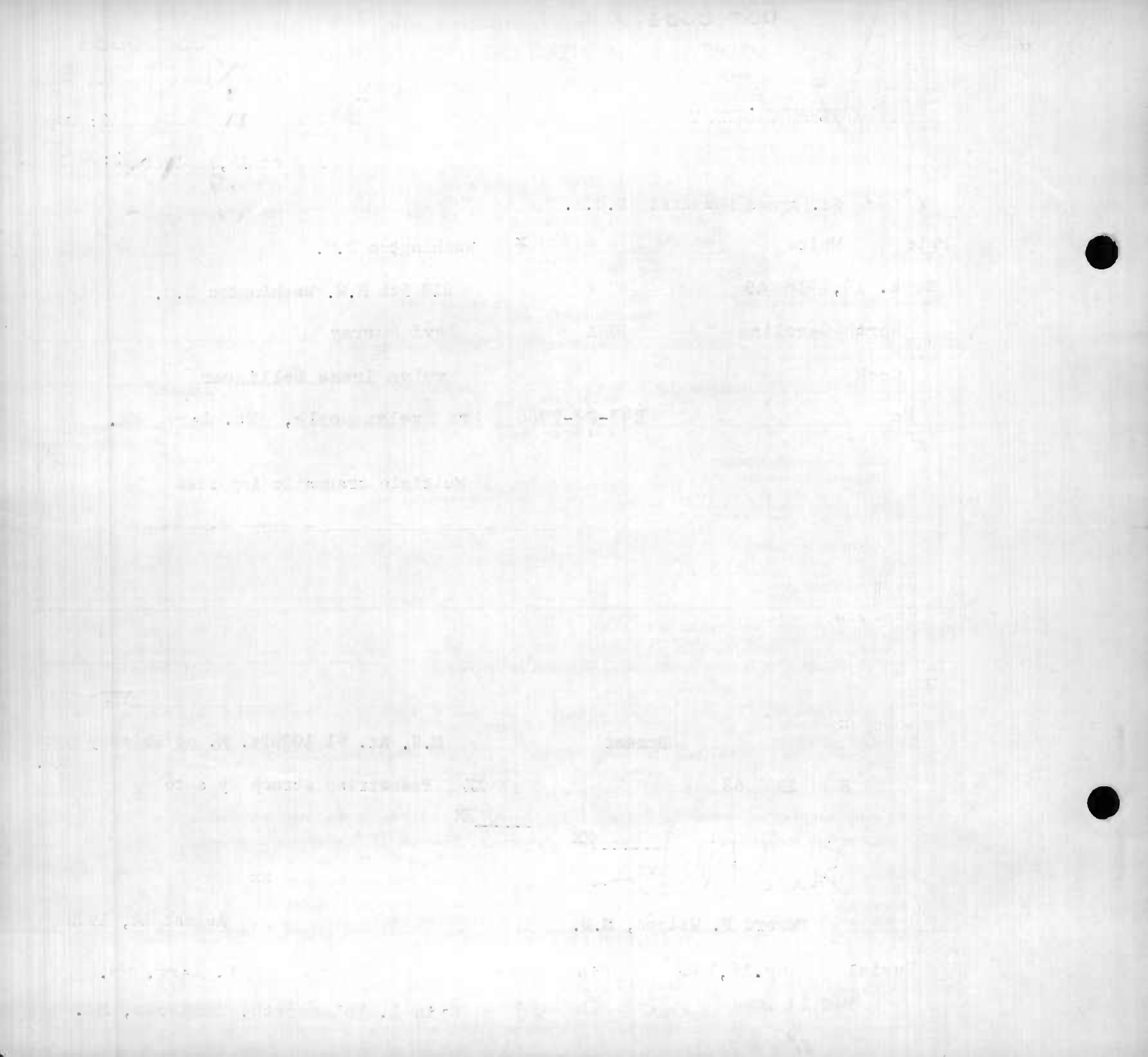
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BOCKMILLER, WALTER BELL</b>		2. DATE AND HOUR OF DEATH <b>AUGUST 11, 1968 11:10A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>A.A.C. 52-00</b>		C. CITY OR TOWN <b>PASADENA</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST AGNES HOSPITAL CATON &amp; WILKENS AVE BALTO. MD 21229</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>60 JOHNSON RD</b>		5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>03 16 99</b>		9. AGE (In years last birthday) <b>69</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAIL DELIVERER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Post Office</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>William Bockmiller</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Bowen</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217126869</b>		17. INFORMANT <b>ST AGNES RECORDS-CATON &amp; WILKENS AVE</b>	
18. <b>411.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTecedent CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>420.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Broncho pneumonia</b> (B) <b>Coronary Insufficiency</b> (C) <b>Generalized Atherosclerosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>X(I)</b> (this hospital) attended the deceased from <b>JULY 27</b> 19 <b>68</b> to <b>AUG. 11</b> 19 <b>68</b> , that <b>X(I)</b> (we) last saw the deceased alive on <b>AUG. 11</b> 19 <b>68</b> and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above <b>X(I)</b> (We) (did) <b>XXXX</b> view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED <b>08 11 68</b>		23C. PHYSICIAN'S NAME (Type) <b>SALVADOR QUIROZ</b>	
23D. ADDRESS <b>ST AGNES HOSP. BALTO MD 21229</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>8-14-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION <b>Baltimore, Maryland</b>		24E. DATE REC'D BY HEALTH DEPT. <b>AUG 16 1968</b>	
24F. NAME OF REGISTRAR <b>Robert E. Fairbanks</b>		24G. FUNERAL DIRECTOR <b>George J. Gonce</b>		24H. ADDRESS <b>4001 Ritchie Hwy., Baltimore</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 8384

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>SYLVANUS S. SYLVANUS MURRAY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>8</b> Day <b>13</b> Year <b>68</b> Hour <b>12:00</b> p.m. Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>40 99 St. Agnes Hospital D.O.A.</b>		3. DATE PRONOUNCED DEAD Month <b>August</b> Day <b>13</b> Year <b>1968</b> Hour <b>12:00</b> p.m.	
6. SEX <b>Male</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Washington D.C.</b> B. COUNTY	
7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	C. CITY OR TOWN <b>Washington D.C.</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>Sept. 19, 1918</b>	10. AGE (In years lost birthday) <b>49</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER <b>810 5th N.W. Washington D.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		13. FATHER'S NAME <b>Levi Murray</b>	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Evelyn Irene Dellinger</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>243-22-7966</b>	
18. INFORMANT <b>Mrs Evelyn Hoyle, Mt. Airy Md.</b>		ADDRESS	
19. <b>E814.7 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  <b>E812.4 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Multiple traumatic injuries</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>U.S. Rt. #1 1000ft. N. of Whiskey Bottom Rd.</b>		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>8 13 68</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Pedestrian struck by auto</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>August 14, 1968</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 16, 1968</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Pine Grove</b>		24D. LOCATION (City, town, or county) (State) <b>Mt. Airy, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 16 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>	
25C. FUNERAL DIRECTOR <b>Olin L. Molesworth, Damascus, Md.</b>		ADDRESS	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8385

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

BERTHA

FORD

2. DATE  
OF  
DEATHKnown ☐ Estimated ☒

Month

Day

Year

Hour

August

12,

1968

2:20 A. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If not in hospital or institution, give street  
address or location)

Johns Hopkins Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

August 12, 1968

2:20 A. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

female

7. RACE

negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS

YES ☒NO ☐

9. DATE OF BIRTH

9- -13

10. AGE (In years  
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

945 N. Broadway

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Titus Tucker

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Virginia Seamore

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

E916.0 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Smoke and Soot Inhalation

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

home

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

945 N. Broadway

22D. TIME  
OF INJURY  
(APPROX.)

8/12/68 1:50 A. m.

22E. INJURY OCCURRED  
WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒22F. HOW DID INJURY OCCUR? Subj. burned in house  
fire; cause of fire undetermined

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/12/68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8-16-68

24C. NAME of CEMETERY or CREMATORY

Harmony Memorial Park

24D. LOCATION (City, town, or county)

Landover, P. G., County, Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 16 1968

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Hall Bros. Funeral Home

ADDRESS

621 Fla., Ave., N.W., Washington, D. C.

Handwritten signature or initials.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8386	
<div style="display: flex; justify-content: space-between;"> <span>m-200</span> <span>68- 8386</span> <span>CERTIFICATE OF DEATH</span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MOSS, LILLIAN		8/12/68 6:35 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL			A. STATE <del>NEW YORK</del> NEW YORK V-29		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY		
			C. CITY OR TOWN <del>BRONX</del> BRONX		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 2780 UNIVERSITY AVE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/21/07	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTO.	
13. FATHER'S NAME JACOB LEVIN		14. MOTHER'S MAIDEN NAME REBECCA DEINER		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MR. BEN MOSS, 2780 UNIVERSITY AVENUE BRONX, NEW YORK	
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CEREBRAL METASTASIS OR HEART FAILURE 1 MONTH			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) CARCINOMA - PROBABLE OVARIAN DUE TO, OR AS A CONSEQUENCE OF:		
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 175.0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 28 1968 to Aug 12 1968 that (I) (we) last saw the deceased alive on Aug 12 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Karl Rosenfeld, M.D.				23B. DATE SIGNED 8/12/68	
23C. PHYSICIAN'S NAME (Type) KARL ROSENFELD, M.D.				23D. ADDRESS Sinai Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL-BURIAL		24B. DATE 8-14-68		24C. NAME OF CEMETERY or CREMATORY MONTIFIORE	
24D. LOCATION LONG ISLAND, NEW YORK		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	
25D. ADDRESS					



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 8387
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SARAH CHISLOW		8/12/68 5 <sup>45</sup> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  LEVINDALE NURSING HOME			A. STATE MARYLAND		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER LEVINDALE AGED HOME		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-1877	9. AGE (In years lost birthday) 90	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MR. SAMUEL GORMAN, 110 SHERWOOD AVE. #21208	
18. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 h.		
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Heart Failure					
(B) Chronic Coronary Insufficiency several years					
(C) Arteriosclerotic Cardiovascular Disease many years					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II Diabetes Mellitus					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to August 12 1968, that (I) (we) last saw the deceased alive on 8/12 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Agustin Collado</i>				23B. DATE SIGNED 8/12/68	
23C. PHYSICIAN'S NAME (Type) AGUSTIN COLLADO, M.D.				23D. ADDRESS Sinai Hospital of Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-14-68		24C. NAME of CEMETERY or CREMATORY TZ EMECH ZEDEK, SHOMRA HADATH	
				24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE RECEIVED BY HEALTH DEPT. AUG 16 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

1. *Leptococcus* *fluorescens* *Waller*

2. *Leptococcus* *fluorescens* *Waller*

*Leptococcus* *fluorescens* *Waller*

*Leptococcus* *fluorescens* *Waller*

*Leptococcus* *fluorescens* *Waller*

8/10

*Leptococcus* *fluorescens* *Waller*

*Leptococcus* *fluorescens* *Waller*

*Leptococcus* *fluorescens* *Waller*

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 12-300				68- 8388				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8388			
1. NAME OF DECEASED (Type or Print) <b>SAMUEL RUDE</b>								2. DATE AND HOUR OF DEATH <b>8-13-68 11:15 a.m.</b>							
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LEVINDALE HEBREW HOME &amp; INF. Belvedere at Greenspring Ave.</b>								<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>7902 TERRAPIN COURT</b>							
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>[REDACTED]</b>		9. AGE (In years last birthday) <b>90</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SELF EMPLOYED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>COOPERAGE</b>	
11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>								12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JACOB RUDE</b>								14. MOTHER'S MAIDEN NAME <b>RIVKA ?</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>NO</b>								16. SOCIAL SECURITY NO.				17. INFORMANT <b>Mrs. Lilyan Navidsky</b> ADDRESS <b>7902 Terrapin Court Baltimore, Md. 21204</b>			
18. <b>410.9 I</b> CAUSE OF DEATH															
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.								<b>(A) IMMEDIATE CAUSE</b> <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF:  <b>(B) ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF:  <b>(C)</b>							
<b>420.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).															
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>NO</b>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)								21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)								21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8-4-1961</b> to <b>8-13-1968</b> , that (I) (we) lost saw the deceased alive on <b>8-13-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE <b>[Signature]</b>								Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> DEGREE				23B. DATE SIGNED <b>8-13-68</b>			
23C. PHYSICIAN'S NAME (Type) <b>JOSE ARDAIZ</b>								23D. ADDRESS <b>7 OBERLIN COURT, Towson Md. 21204</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				24B. DATE <b>8-14-68</b>		24C. NAME of CEMETERY or CREMATORY <b>TIFERETH ISRAEL ANSHE SFARD</b>				24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 16 1968</b>				25B. NAME OF REGISTRAR <b>[Signature]</b>				25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>							

10

4

1990-1991



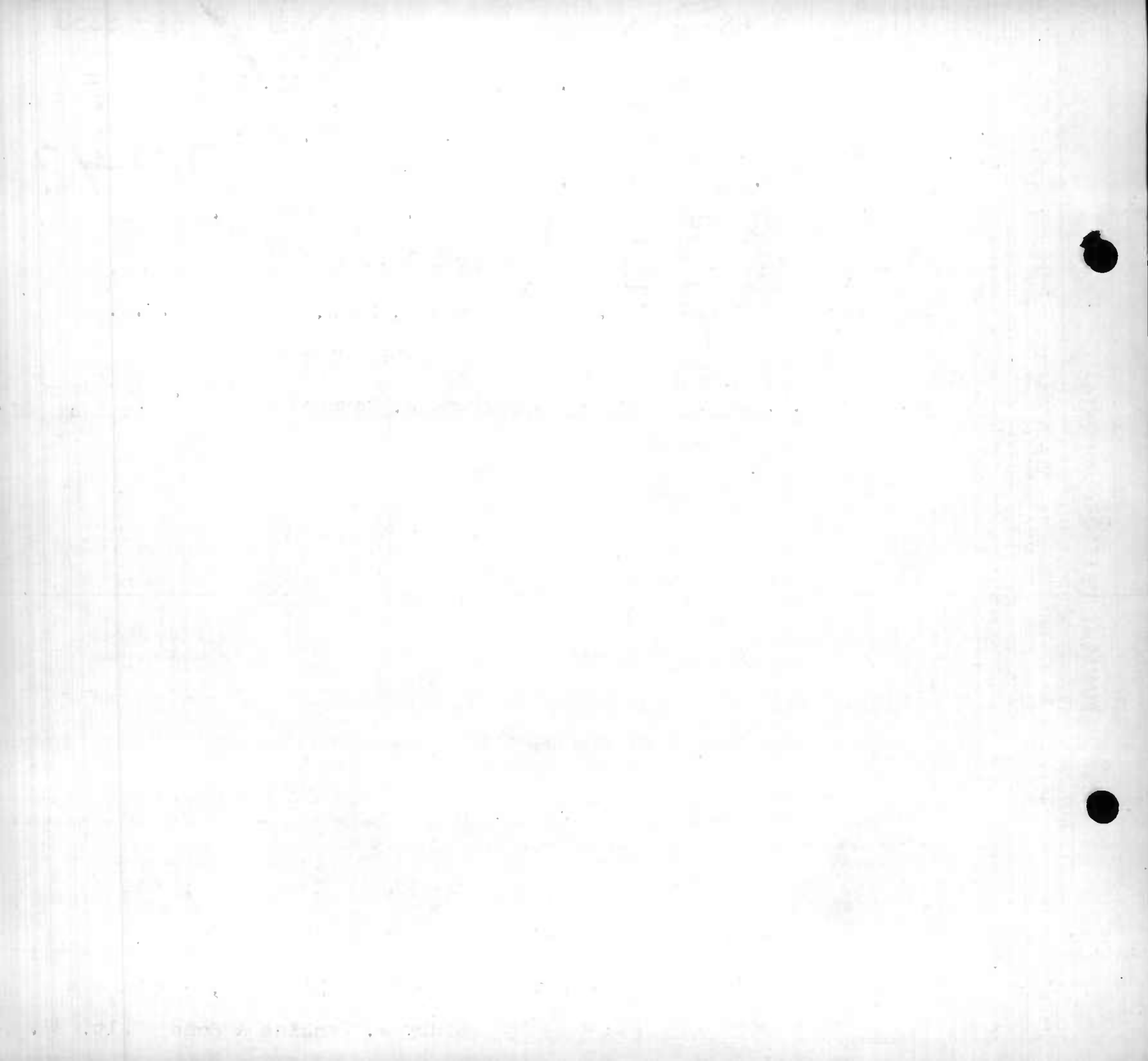
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8389 CERTIFICATE OF DEATH

REG. NO. 68- 8389

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Herbert Maynard Jr.		August 13, 1968 3:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00			A. STATE B. COUNTY Md. Balt. City		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 902 W. Belvedere Ave.			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 902 W. Belvedere Ave.		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	April 18, 1885	83	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Importer		Maynard & Child Inc.		Boston, Mass.	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Herbert Maynard			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
Yes			W.W. I 218 03 5926		Irene J. Maynard
			18. CAUSE OF DEATH		ADDRESS 902 W. Belvedere Avenue
1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Vascular collapse DUE TO, OR AS A CONSEQUENCE OF: (B) Secondary antitumor - old CVA DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 331X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 19 58 to Aug 13 1968, that (I) (we) last saw the deceased alive on Aug 13 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Walter B. Buck MD				23B. DATE SIGNED 8/14/68	
23C. PHYSICIAN'S NAME (Type) WALTER B. BUCK				23D. ADDRESS 18 E EAGER - 21202	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Cremation		8 15 68		Green Mount Crematory	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS Henry W. Jenkins & Sons Balt. Md.	



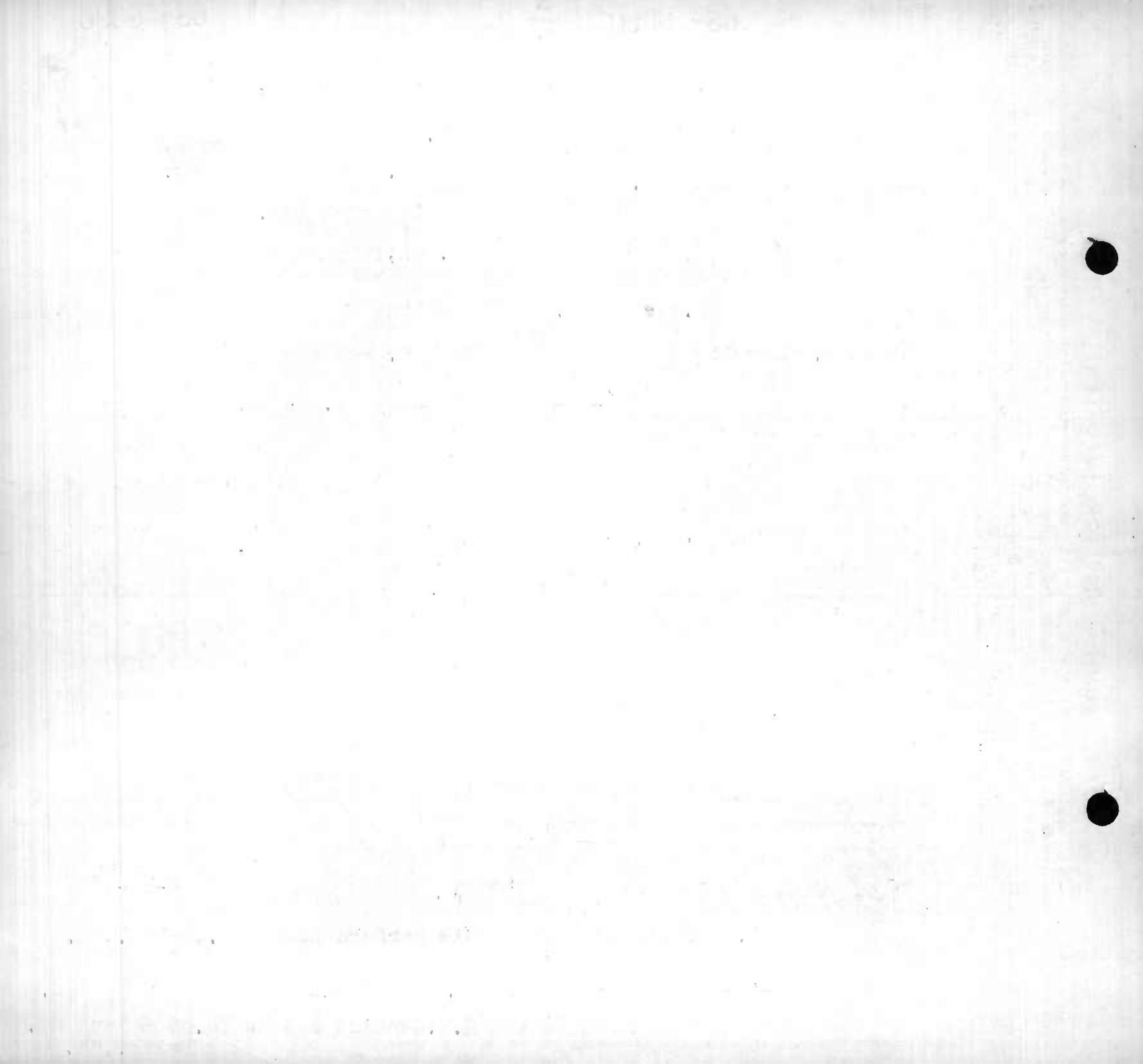
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

68- 8390

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 8390

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ROLAND J. CARROLL		August 15, 1968 3 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
00 4201 Heckel Ave.				Md. C. CITY OR TOWN D. INSIDE CITY LIMITS? Balto. 21206 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 4201 Heckel Ave.					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 31, 1903	64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Artist		A. Horn & Co.		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William J. Carroll		Mary L. McSherry		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		215-09-7991		Elizabeth B. Carroll Same	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1B. 410.9 + 1011.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				2 yrs.	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL INFARCT				3 YRS	
(B) COR PULMONALE DUE TO, OR AS A CONSEQUENCE OF: OBSTRUCTIVE EMPHYSEMA + Fibrosis				5 YRS	
(C) PULMONARY TUBERCULOSIS				10 YRS	
				14 YRS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 12/1 1956 to 8/15 1968, that (I) last saw the deceased alive on JULY 30 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
John H. Hirschfeld M.D.				8-16-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
John H. Hirschfeld MD				6919 Harford Road, Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8-19-68		New Cathedral	
				Baltimore Md.	
25A. DATE RECEIVED FOR HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 16 1968		Robert E. Jenkins		H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68- 8391</b>
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Alma Esther BAILEY</b>		2. DATE AND HOUR OF DEATH <b>8/15/68</b> <b>9:45 A.M.</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>774 Union Memorial Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>12-01</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>774 Union Memorial Hospital</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>106 W. UNIVERSITY PKW.</b>		<b>BALTIMORE 10. 1979</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-21-90</b>	9. AGE (In years lost birthday) <b>77</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H SWF.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Joseph H. NEELY</b>		
14. MOTHER'S MAIDEN NAME <b>MOLLIE PARSONS</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO. <b>213-38-7844</b>		17. INFORMANT <b>MRS. ANNE B. SWAIN SILVER SPRING, MD.</b>		
18. <b>22301</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Angioma</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Brain Tumor</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Reg. failure &amp; Cause</b> (C) <b>Reg. failure &amp; Cause</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>2233X II</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
19A. DATE OF OPERATION <b>8/8/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Brain Angioma</b>		20A. AUTOPSY? (Yes or No) <b>Yes (brain)</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or on body, home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>2/28</b> 19 <b>68</b> to <b>8/15</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/15/</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>N. H. Jenkins</b>		23B. DATE SIGNED <b>8/15/68</b>		23C. PHYSICIAN'S NAME (Type) <b>NOUBAR H. DIDIZIAN MD</b>
23D. ADDRESS <b>U.M.H.</b>		23E. DEGREE <b>MD</b>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-19-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge</b>
24D. LOCATION <b>Pikesville</b>		<b>Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 16 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>
25D. ADDRESS <b>4905 York Rd.</b>		<b>Balto., Md.</b>		

Charles Johnson

Johnson (no name)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-621 68-8392 BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68-8392	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO.</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <b>Finley S. Bowers</b></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <b>8-15-68 12 20/P M.</b></p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>44 Union Memorial Hosp.</b></p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>12-01</b> D. STREET ADDRESS (If rural, give location) <b>3510 Greenmount Ave</b></p>		
<p>5. SEX <b>Female</b></p>	<p>6. RACE <b>White</b></p>	<p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b></p>	<p>8. DATE OF BIRTH <b>8-10-97</b></p>	<p>9. AGE (In years last birthday) <b>71</b></p>	<p>If Under 1 Yr. Months: Days: Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired HSWFE.</b></p>			<p>10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b></p>		<p>11. BIRTHPLACE (State or foreign country) <b>Virginia</b></p>
<p>12. CITIZEN OF WHAT COUNTRY? <b>America</b></p>			<p>13. FATHER'S NAME <b>Marvin Sutherland</b></p>		
<p>14. MOTHER'S MAIDEN NAME <b>Jennie Holston</b></p>			<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b></p>		
<p>16. SOCIAL SECURITY NO. <b>215-01-8500</b></p>			<p>17. INFORMANT ADDRESS <b>MRS. Mary BUCKINGHAM 3445 Old York Rd.</b></p>		
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>410.9 + 450.9</b></p>			<p>CAUSE OF DEATH <b>Chronic Ischemic heart disease; Cerebrovascular accident</b></p>		
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>420.1 II</b></p>			<p>INTERVAL BETWEEN ONSET AND DEATH <b>Diabetes Mellitus Y.S.</b></p>		
<p>19A. DATE OF OPERATION <b>8-15-68</b></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Diabetes Mellitus</b></p>		<p>20A. AUTOPSY? (Yes or No) <b>Yes</b></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Y.S.</b></p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Y.S.</b></p>	
<p>21D. TIME OF INJURY (APPROX.) <b>7-01-</b></p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR? <b>19 68 to 8-15 19 68</b></p>	
<p>22. I certify that (H) (this hospital) attended the deceased from <b>7-01-</b> <b>19 68</b> to <b>8-15 19 68</b>, that (H) (we) last saw the deceased alive on <b>8-15 19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <b>Stephen Goldberg</b></p>			<p>23B. DATE SIGNED <b>8-15-68</b></p>		<p>23C. PHYSICIAN'S NAME (Type) <b>STEPHEN GOLDBERGER</b></p>
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>			<p>24B. DATE <b>8-19-68</b></p>		<p>24C. NAME OF CEMETERY or CREMATORY <b>Moreland</b></p>
<p>24D. LOCATION (City, town, or county) (State) <b>Balto. Balto. Md.</b></p>			<p>25A. DATE REC'D BY HEALTH DEPT. <b>AUG 16 1968</b></p>		
<p>25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b></p>			<p>25C. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto., Md.</b></p>		

9/16

Long Bay, N. Y.

body  
 10/1/10  
 2210 Greenway Ave  
 8-10-11 11  
 Virginia  
 Jennie Hobson

Chas. Marshall  
 female white woman  
 retired  
 Martin Sutherland

~~Carroll's first flight~~  
~~Carroll's first flight~~  
 the number of flights  
 white high school  
 February school

2x  
 Diaper Mellitus

21-8 08

7-01-08

8-12

8-12-08

3211-0 Steele 39

*John J. [Signature]*  
 10/1/10

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

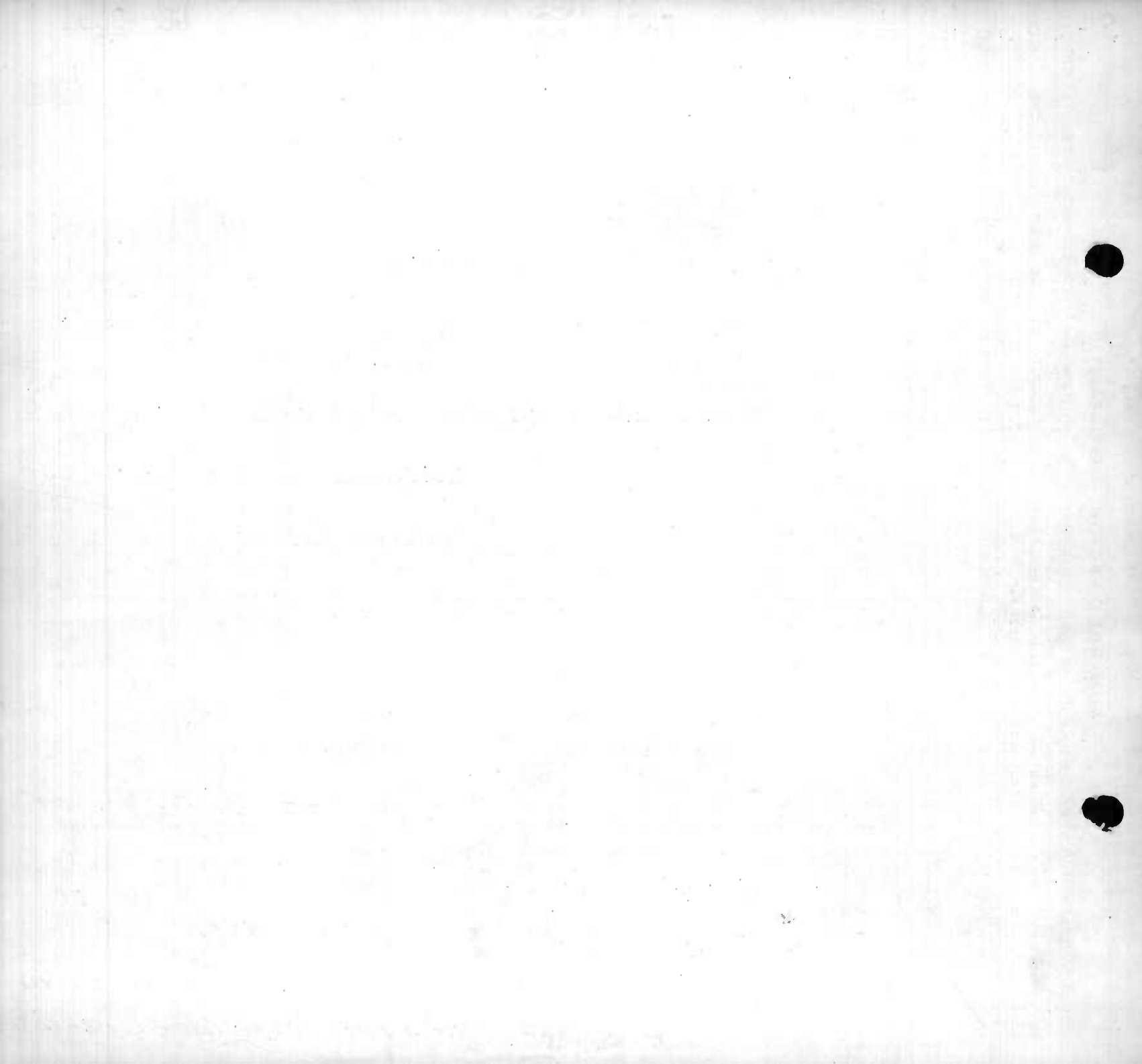
BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8393					
1. NAME OF DECEASED (Type or Print) <b>Joseph Norman</b>				2. DATE AND HOUR OF DEATH <b>8-16-68 1215 A</b>									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto.</b>									
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 The Johns Hopkins Hospital</b>				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <b>1905 E. Pratt St.</b>									
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-01-83</b>	9. AGE (In years last birthday) <b>85</b>	If Under 1 Yr. Months: Ooys: If Under 24 Hrs. Hours: Min.								
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CONDUCTOR</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>BALTO TRANSIT CO</b>				11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>JOSEPH NORMAN</b>				14. MOTHER'S MAIDEN NAME <b>MARY TIPPLER</b>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>213-10-1344A</b>				17. INFORMANT <b>JOSEPH J GERGLEY</b>				ADDRESS <b>523 NEWFIELD RD SW GLEN BURNIE MD</b>	
18. I <b>7-69</b> I <b>1</b> CAUSE OF DEATH				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Prob C. U.A. Retention</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>BPH - 5 Acute Clamag</b> DUE TO, OR AS A CONSEQUENCE OF:				<b>3 hrs</b>					
(C) _____													
19. DATE OF OPERATION <b>7-29-68</b>				20. AUTOPSY? (Yes or No) <b>NO</b>				21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NO</b>				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NO</b>					
21D. TIME OF INJURY (APPROX.) <b>NO</b>				21E. INJURY OCCURRED While At <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR? <b>NO</b>					
22. I certify that (I) (this hospital) attended the deceased from <b>7-29</b> 19 <b>68</b> to <b>8-16</b> 19 <b>68</b> that (I) (we) lost saw the deceased alive on <b>8-16</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.													
23A. SIGNATURE <b>M. F. Carter MD</b>				23B. DATE SIGNED <b>8-16-68</b>									
23C. PHYSICIAN'S NAME (Type) <b>M. F. Carter</b>				23D. ADDRESS <b>Johns Hopkins Hospital</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				24B. DATE <b>AUG 19 1968</b>				24C. NAME OF CEMETERY or CREMATORY <b>MT CARMEL CEMETERY</b>				24D. LOCATION (City, town, or county) (State) <b>O'DONNELL ST BALTO MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>				25B. NAME OF REGISTRAR <b>John E. Taylor</b>				25C. FUNERAL DIRECTOR <b>DIPPEL BROS INC</b>				ADDRESS <b>1800 E LOMBARD ST</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

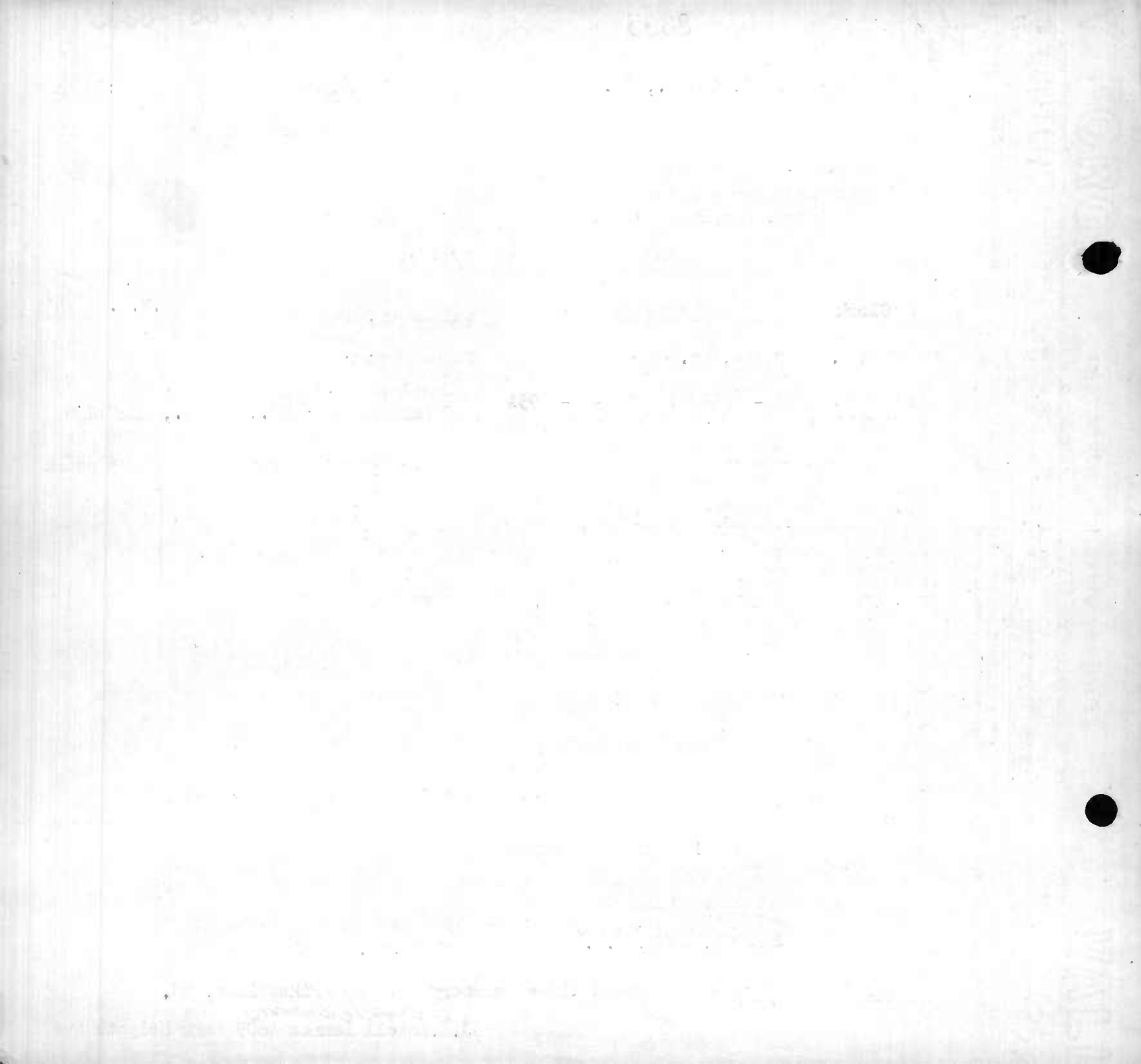
BALTIMORE CITY HEALTH DEPARTMENT											
68- 8394					REG. NO. 68- 8394						
BIRTH NO.					1. NAME OF DECEASED (Type or Print)						
					Herman Sturmer						
2. DATE AND HOUR OF DEATH					Aug 16 - 68 early A.M.						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
					A. STATE Md. B. COUNTY 2-02						
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN Balto						
					D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
E. STREET AND NUMBER					25 S. Durham St.						
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)			
Male		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Jan 4 1895		73			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS, OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
habon			Retired			Germany			U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
? Sturmer					Elizabeth ?						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS	
No					215-128348		Louis Sturmer			22 2049 Jasmine Rd	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					chronic bronchitis several years	
ANTECEDENT CAUSES					(B) DUE TO, OR AS A CONSEQUENCE OF:					emphysema	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C)						
502.0 II					OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).						
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0						NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?					
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>								
22. I certify that (I) (this hospital) attended the deceased from 17 Aug 1966 to 17 Aug 1968, that (I) (we) last saw the deceased alive on 17 Aug 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE					23B. DATE SIGNED						
J Hulla M.D.					17 Aug 68						
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS						
J Hulla M.D.					2214 9 Fayette St						
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE			24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
BURIAL			AUG 19 1968			MT CARMEL CEMETERY			O'DONNELL ST. BALTO MD		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR			ADDRESS		
AUG 19 1968			R. L. E. 2, Inc.			THE DIPPEL BROS INC			1800 E LOMBARD ST		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-8395	
68-8395				CERTIFICATE OF DEATH	
BIRTH NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>EBERWEIN, William F., Jr.</b>			8/15/68 7:20 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>			A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel</b> 52-00		
5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			C. CITY OR TOWN <b>Pasadena</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>			E. STREET AND NUMBER <b>8407 Hall Road</b>		
10B. KIND OF BUSINESS OR INDUSTRY <b>Ship Yard</b>			8. DATE OF BIRTH <b>6/16/93</b> 9. AGE (In years last birthday) <b>75</b>		
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>William F. Eberwein, Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Foster</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 6/22/18 - 9/11/19</b>			16. SOCIAL SECURITY NO. <b>216-09-8695A</b>		
17. INFORMANT <b>VA Hospital Records</b>			ADDRESS <b>3900 Loch Raven Blvd., Balto., Md 21218</b>		
18. I <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE <b>Bronchogenic Carcinoma</b>		
ANTECEDENT CAUSES			DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>August 7th 1968</b> to <b>August 15th 1968</b> , that <del>(X)</del> (we) last saw the deceased alive on <b>August 15th 1968</b> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(X)</del> (We) (did) <del>(not)</del> view the body after death.					
23A. SIGNATURE <b>YOUNG E. CHUN, M.D.</b>				23B. DATE SIGNED <b>8/15/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>YOUNG E. CHUN, M.D.</b>				23D. ADDRESS <b>3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/17/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Pikesville, Md.</b>		24E. NAME OF REGISTRAR <b>Robert E. Jackson</b>		24F. ADDRESS <b>J.E. Lowell Lemmon 4609 Park Heights Ave</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>J.E. Lowell Lemmon</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">68- 8396</span>	
1. NAME OF DECEASED (Type or Print) <b>Alexander A. Kelly</b>				2. DATE AND HOUR OF DEATH <b>August 14, 1968</b> <b>8:30</b> <b>A</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>5205 Ethelbert Ave.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>5205 Ethelbert Ave</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 3, 1893</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse(Retired)</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>John Kelly</b>				
14. MOTHER'S MAIDEN NAME <b>unknown</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>W.W. 1</b>				
16. SOCIAL SECURITY NO. <b>218 10 4894</b>			17. INFORMANT ADDRESS <b>Helen M. Kelly 5205 Ethelbert Ave.</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>4/10.9 I</b> <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Anteriosclerotic cardiovascular disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>Several years</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>420.1 II</b>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>May 1964</b> to <b>August 14, 1968</b> that (I) ( <del>we</del> ) last saw the deceased alive on <b>Aug 13, 1968</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>Seymour H. Rubin</b>				23B. DATE SIGNED <b>8/14/68</b>			
23C. PHYSICIAN'S NAME (Type) <b>Seymour H. Rubin, M.D.</b>				23D. ADDRESS <b>5413 Park Heights Ave Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/16/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>J.E. Lowell Lemmon</b> ADDRESS <b>4609 Park Heights Ave</b>			

Mr. J. J. [illegible]

Mr. [illegible]

Mr. [illegible]

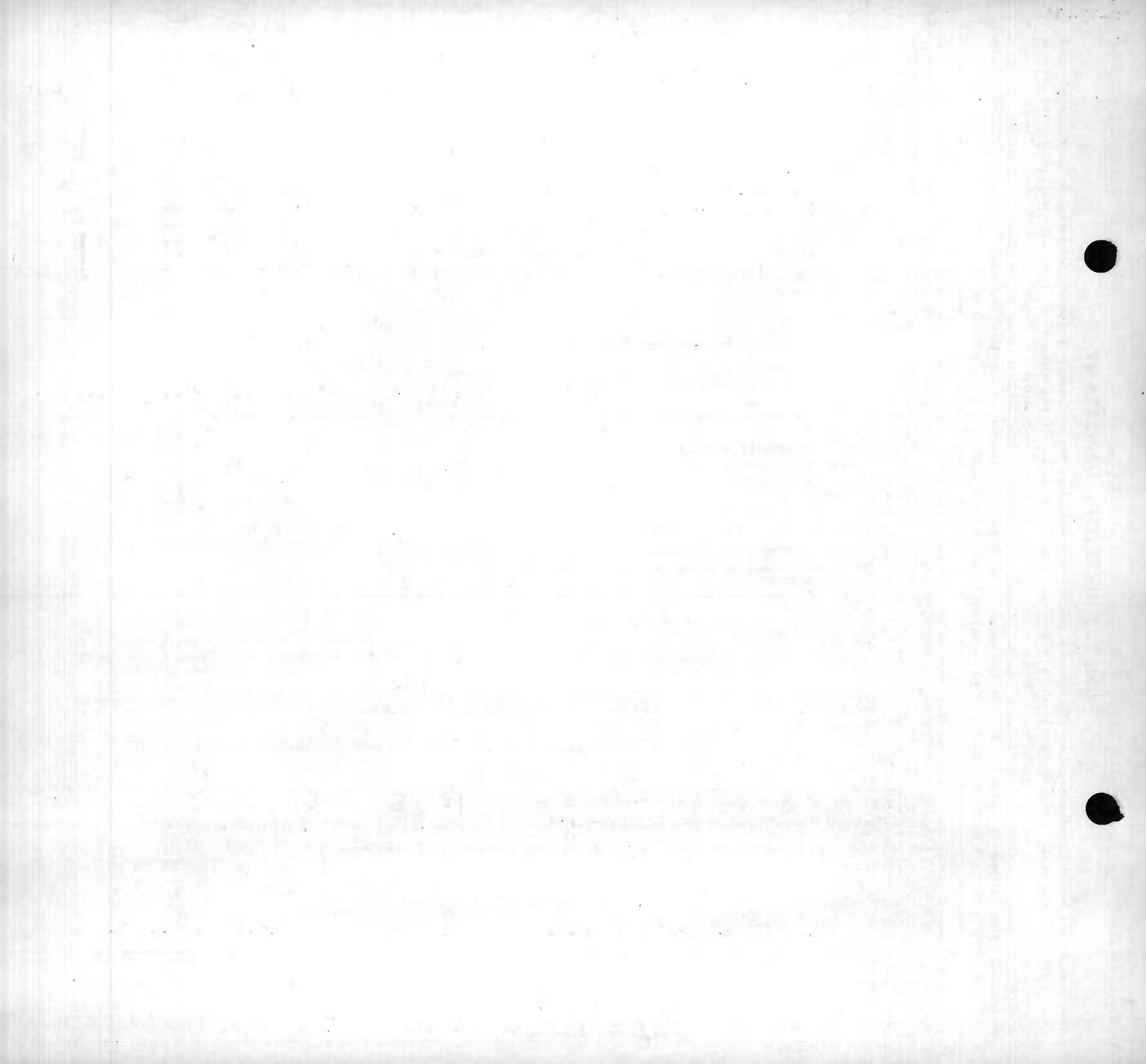
Mr. [illegible]

Mr. [illegible]

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8397	
5-322 68- 8397				CERTIFICATE OF DEATH	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>Rose Stasuk</b> [Rose Grubowska Stasuk]	
2. DATE AND HOUR OF DEATH <b>8-15-68</b> <b>7:00 a.m.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>3-01</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND 21224</b>				C. CITY OR TOWN <b>BALTIMORE</b>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>410 S. DALLAS ST. 21224</b>	
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>9-20-23</b>		9. AGE (In years last birthday) <b>44</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>STEPHEN GRUBOWSKI</b>		14. MOTHER'S MAIDEN NAME <b>MARY Guzinski</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>BCH: RECORDS 4940 EASTERN AVE., BALTO., MD.</b> <b>Steven Grubowski, 410 S. Dallas St. 21224</b>	
18. <b>174X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>170X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>carcinoma of the breast &amp; multiple metastases</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-8</b> 19 <b>67</b> to <b>8-15</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8-14</b> - 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>R. Christopher Stucky</b>				23B. DATE SIGNED <b>8-15-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>R. CHRISTOPHER STUCKY M.D.</b>				23D. ADDRESS <b>BCH: 4940 EASTERN AVE., BALTO., MD. 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/19/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Stanislaus</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		24F. NAME OF REGISTRAR <b>Robert E. Tarkenton</b>	
24G. FUNERAL DIRECTOR <b>M. F. SADOWSKI &amp; SONS, 1808 EASTERN AVE</b>		24H. ADDRESS <b>BALTO., MD. 21224</b>		24I. DATE OF DEATH <b>8-15-68</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

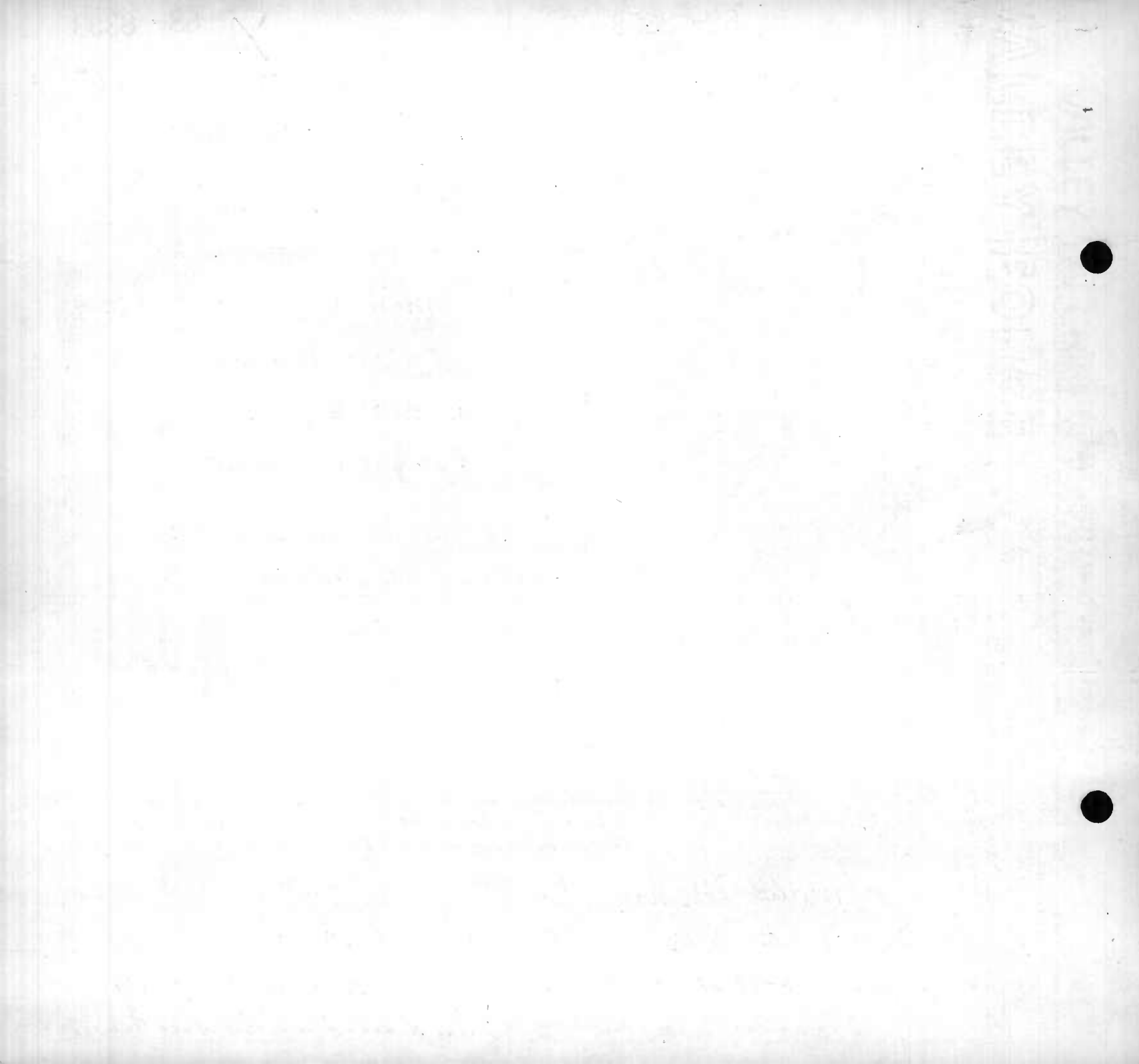
68- 8398

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68- 8398

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JOAN A. LEWIS</b>		2. DATE AND HOUR OF DEATH <b>8-15-68</b> <b>12<sup>45</sup> P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>ANNE ARUNDEL</b> C. CITY OR TOWN <b>PASADENA</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NDT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SOUTH BALTO. GEN. HOSPITAL</b> <b>43</b>			E. STREET AND NUMBER <b>RT 1 Box 244</b>		
5. SEX <b>F</b>	6. RACE <b>white</b> <b>CAUC</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-27-32</b>	9. AGE (In years last birthday) <b>36</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>
13. FATHER'S NAME <b>GEORGE BAUMAN</b>			14. MOTHER'S MAIDEN NAME <b>JOHANNA HIMMEL HEBEN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT ADDRESS <b>HUSBAND</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>322 X 4-250.9</b> (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>342 X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>DIABETES MELLITUS</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>RESPIRATORY ARREST</b> (B) ACUTE BRAIN SWELLING DUE TO, OR AS A CONSEQUENCE OF: <b>CEREBELLAR ABSCESS</b> (C) <b>-</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>2 -</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) <b>-</b>		21C. WHERE DID INJURY OCCUR? <b>-</b>	
21D. TIME OF INJURY (APPROX.) <b>-</b>		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>8-12</b> 19 <b>68</b> to <b>8-15</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8-15</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Donald M. Wood MD</b>				23B. DATE SIGNED <b>8-15-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>DONALD M. WOOD MD</b>		23D. ADDRESS <b>South Balto. Gen. Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8-19-68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore 21217, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. J. ...</b>		25C. FUNERAL DIRECTOR ADDRESS <b>John H. Hahn Funeral Home, 4200 Pennington Ave.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8399 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 68- 8399

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Albert G. Laun</b>		2. DATE AND HOUR OF DEATH <b>Aug. 16, 1968 12:05 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>28-04</b>		C. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4909 Edmondson Ave.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>May 20, 1882</b>		9. AGE (In years last birthday) <b>86</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Superintendent</b>	
11. BIRTHPLACE (State or foreign country) <b>Louisville, Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Laun</b>	
14. MOTHER'S MAIDEN NAME <b>Ann Marie Koertner</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-03-4732</b>	
17. INFORMANT <b>Albert J. Laun, 4909 Edmondson Ave., Balto.Md.</b>		ADDRESS		18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis 10 months</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>A.S.C.U.D. years</b>	
19. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 1 1965</b> to <b>Aug 16 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 16 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. C. Pound</b>		23B. DATE SIGNED <b>8/17/68</b>		23C. PHYSICIAN'S NAME (Type) <b>J. C. Pound</b>	
23D. ADDRESS <b>3325 Frederick av Balto Ma</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 19. 1968</b>	
24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland 21229</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>	
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>G. Truman Schwab, 5151 Balto. Ntl. Pike, Balto. Md. 21229</b>		25D. ADDRESS	

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8400 **CERTIFICATE OF DEATH**

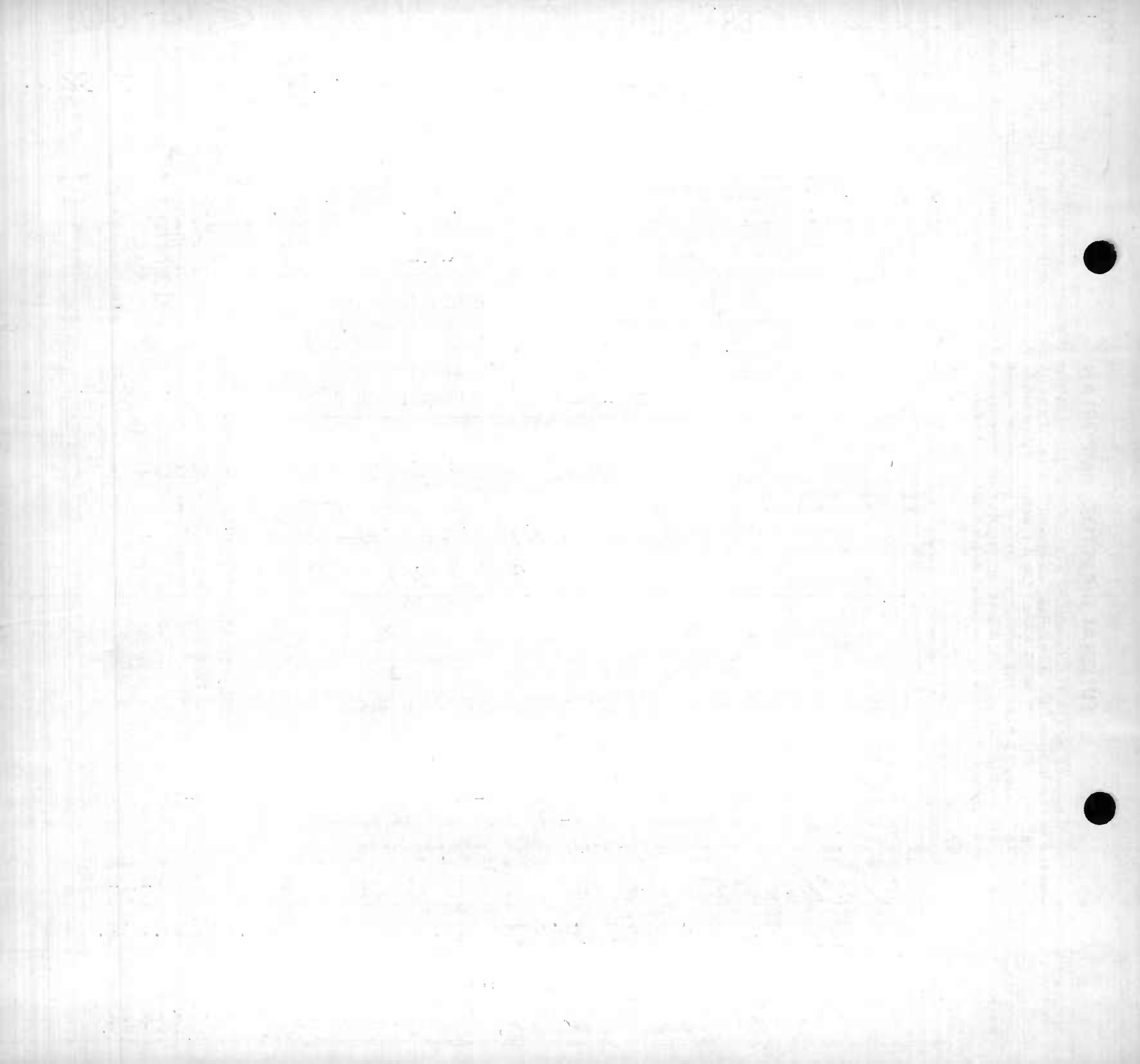
REG. NO. 68- 8400

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WILLIAM YINGLING</b>		2. DATE AND HOUR OF DEATH <b>8/15/68 7:00 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND GEN. HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>26-03</b>	
				C. CITY OR TOWN <b>BALTIMORE</b> INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3405 DUDLEY AVE.</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>2/5/90</b>	9. AGE (in years last birthday) <b>78</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>WILLIAM YINGLING</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWII</b>				14. MOTHER'S MAIDEN NAME <b>KATHERINE WEBER</b>	
16. SOCIAL SECURITY NO. <b>213-81-6374</b>				17. INFORMANT <b>DOPE YINGLING</b> ADDRESS <b>SKA</b>	
18. CAUSE OF DEATH <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>CARDIAC ARREST</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ACUTE MYOCARDIAL INFARCTION</b> <b>ASCVD</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>420.1 II</b>					
19A. DATE OF OPERATION <b>8</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>yes</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7/23</b> 19 <b>68</b> to <b>8/15</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/15</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>E. M. De los Santos Jr. M.D.</b>				23B. DATE SIGNED <b>8/15/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>E. M. De los Santos Jr. M.D.</b>				23D. ADDRESS <b>MD. GEN. HOSP. BALTO, MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-18-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>LORRAINE CEMETERY</b>	
				24D. LOCATION (City, town, or county) (State) <b>BALTO CO., MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>ULBRICH FUNERAL HOME, BALTO, MD.</b>	

Full of interest and life. W.F.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8401	
BIRTH NO. B-424				68- 8401	
1. NAME OF DECEASED (Type or Print) <b>BLANCHE BLACKWELL</b>		2. DATE AND HOUR OF DEATH <b>8-17-68</b> <b>7:30 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND 21224</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>935 S. BAYLIS AVE. 21224</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-17-06</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>	
13. FATHER'S NAME <b>WHITMAN, McGEE</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>245-05-0996</b>		17. INFORMANT <b>RECORDS: BCH</b> ADDRESS <b>4940 EASTERN AVE., BALTO., MD. 21224</b>	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>PULMONARY EMBOLUS</b> (B) <b>CARCINOMA OF CERVIX</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>RADIATION PROCTITIS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. <b>IX</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7-11</b> <b>19 68</b> to <b>8-17</b> <b>19 68</b> , that (I) (we) last saw the deceased alive on <b>8-17</b> <b>19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William E. Powers</b>				23B. DATE SIGNED <b>8-17-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM E. POWERS M.D.</b>		23D. ADDRESS <b>BCH: 4940 EASTERN AVE., BALTO., MD. 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>Aug 19</b>		24C. NAME OF CEMETERY or CREMATORY <b>Kings Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Lanard Hill N.C.</b>		24E. NAME OF REGISTRAR <b>Robert E. Seaburn</b>		24F. FUNERAL DIRECTOR <b>William E. Powers</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Seaburn</b>		25C. FUNERAL DIRECTOR <b>William E. Powers</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		68- 8402	
1. NAME OF DECEASED (Type or Print) <b>Frances M. Meekins</b>				2. DATE AND HOUR OF DEATH <b>8-14-68</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Maryland General Hosp Baltimore, Md</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Maryland General Hosp Baltimore, Md</b>				C. CITY OR TOWN <b>Garrison</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>?</b>	
				E. STREET AND NUMBER <b>Kenmar Ave</b>		<b>53-00</b>	
5. SEX <b>F</b>	6. RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-25-01</b>	9. AGE (In years last birthday) <b>67</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Edward Lorrinore</b>				14. MOTHER'S MAIDEN NAME <b>Buckingham</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-09-8066</b>		17. INFORMANT <b>pt's chart</b>		ADDRESS	
18. <b>1489 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Bronchopneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Carcinoma of Hypopharynx</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <b>Bronchopneumonia</b> (B) DUE TO, OR AS A CONSEQUENCE OF <b>Carcinoma of Hypopharynx</b> (C) <b>—</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>147X II Cobalt therapy - ~ 1967</b>							
19A. DATE OF OPERATION <b>7-28-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Resp. distress</b>		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <b>7-28</b> 19 <b>68</b> to <b>8-14</b> 19 <b>68</b> , that (I) ( <u>we</u> ) last saw the deceased alive on <b>8-14</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>we</u> ) ( <u>did</u> ) (did not) view the body after death.							
23A. SIGNATURE <b>Rolf Niehan</b>				23B. DATE SIGNED <b>8/14/68</b>			
23C. PHYSICIAN'S NAME (Type) <b>Rolf Niehan</b>				23D. ADDRESS <b>Md. Gen. Hosp</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/17/68</b>		24C. NAME OF CEMETERY <b>MT. Olive Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>RANDALLS TOWN, Balto, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>H. J. Eckhardt</b>		ADDRESS <b>Owings Mills Md</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8403 CERTIFICATE OF DEATH				REG. NO. 68- 8403	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>LOUETTA M. RUPPERSBERGER</b>		2. DATE AND HOUR OF DEATH <b>8/15/68</b> <b>7:30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL HOSPITAL</b> <b>48</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>8/24/92</b> 9. AGE (In years last birthday) <b>75</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>GEORGE G. RUPPERSBERGER</b>	
14. MOTHER'S MAIDEN NAME <b>MARY E. DOBERER</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>49-20-5427</b>	
17. INFORMANT <b>U. B. BORDEN (MRS.)</b>		ADDRESS <b>401 1ST ST RD. GLEN BURNIE, MD.</b>		18. <b>410.9</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL INFARCTION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>	
19. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/14</b> 19 <b>68</b> to <b>8/15</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/15</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>E. M. De los Santos Jr. M.D.</b>		23B. DATE SIGNED <b>8/15/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>E. M. DE LOS SANTOS JR. M.D.</b>		23D. ADDRESS <b>MARYLAND GEN. HOSPITAL</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>8-19-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Frederick Ave., Balto. Md.</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Sisk</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>	
				ADDRESS <b>4107 Wilkens Ave. 21229</b>	

1870 Kennedy Ave.

8/24/72

M.D.

Wm. E. Jackson

George E. Jackson

44-30-217 of P. Jackson (W.E.)

10

Investigate Jackson

4561

~~Investigate Jackson~~

Investigate Jackson

8/2

8

8/14

2/1

8/2/72

Wm. E. Jackson

Investigate Jackson

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 8404 CERTIFICATE OF DEATH

REG. NO. 68- 8404

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Walter, Clarence W.		Aug. 16, 1968 8:00 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					
FULL NAME OF HOSPITAL OR INSTITUTION			(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		
The Johns Hopkins Hospital					
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY			
Maryland Baltimore		3-62			
C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER					
107 Albermarle St.					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug. 20, 1892	74 75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Mechanic		B T C		Virginia	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Irvin Walter			Cora B. ( ? )		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		218-28-0826		Mrs. Minnie P. Walter Same as 4 E	
18. CAUSE OF DEATH					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction, VS Embolism Pulmonary					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) Bronchogenic Carcinoma					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
3 8/10/68		Bronchogenic carcinoma		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from July 25 1968 to Aug 16 1968, that (I) (we) last saw the deceased alive on Aug 16 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Howard Snider, M.D.				8/16/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
HOWARD SNIDER				Johns Hopkins Hospital, Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8-19-68		Parkwood Cemetery	
				Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 19 1968		Robert E. Jenkins		Wm. Cook-Brooks Inc. 1217 St. Paul St.	

Handwritten text, possibly a signature or name, oriented vertically.

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Handwritten text, possibly a signature or name, oriented vertically.

Handwritten text, possibly a signature or name, oriented vertically.

Handwritten text, possibly a signature or name, oriented vertically.

Handwritten text, possibly a signature or name, oriented vertically.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8405 BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 8405

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

METUSAVEG, JOHN STANLEY

2. DATE AND HOUR OF DEATH

AUGUST 13, 1968 6:32P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

ST AGNES HOSP. BALTO MD 21229  
CATON & WILKENS AVE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

Balt Co

53-00

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

200 S SYMINGTON AVE

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

05 28 95

9. AGE (In years lost birthday)

73

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED - CARPENTER U.S. COAST GUARD

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

FELIX METUSAVEG

14. MOTHER'S MAIDEN NAME

FRANCES

TOHASEWICZ

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

YES

W W 1

16. SOCIAL SECURITY NO.

217010228

17. INFORMANT

ADDRESS

ST AGNES RECORDS-BALTO MD 21229

18.

153.8 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

Lung edema

(B) DUE TO, OR AS A CONSEQUENCE OF:

Uremia, hypertension

(C) DUE TO, OR AS A CONSEQUENCE OF:

Ca of the Colon & meta.

Ca of the Colon & meta.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

153.8 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JUNE 23 19 68 to AUG 13 19 68, that (I) (we) last saw the deceased alive on AUG 13, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

N. R. MURPHY M.D.

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

8/13-68

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

St. Agnes Hosp.

DEGREE

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-17-68

24C. NAME OF CEMETERY or CREMATORY

Cathedral Cmn.

24D. LOCATION

(City, town, or county)

Baltimore, Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 19 1968

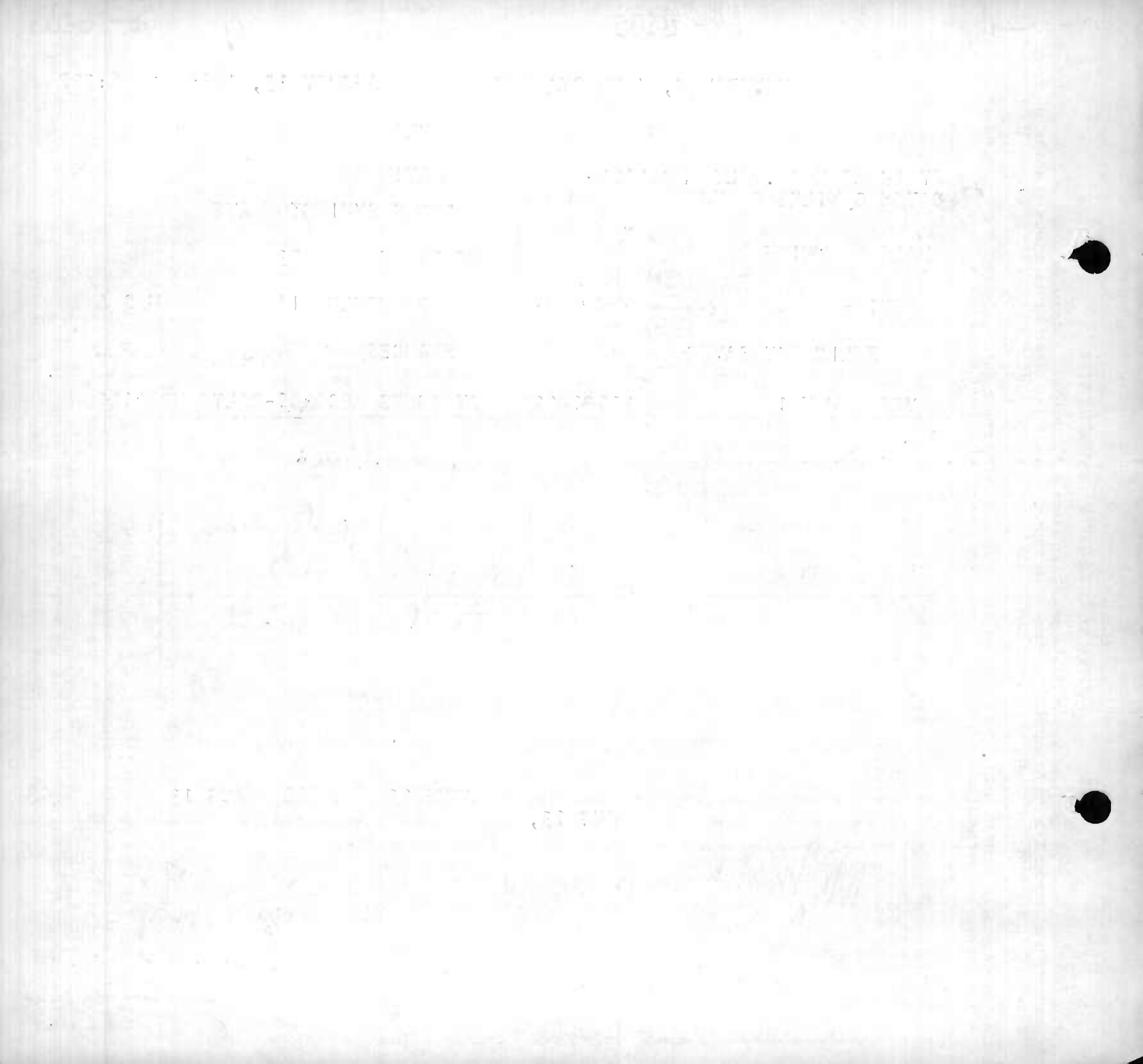
25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Stanley - Company & H. Cotterwood & H.

ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8406 CERTIFICATE OF DEATH

REG. NO. 68- 8406

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>EDMOND P GALIANO</b>		2. DATE AND HOUR OF DEATH <b>8/15/68 9:30 pm 9:30 p.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>	
E. STREET AND NUMBER <b>40 1301 GLENWILDE RD 53-00</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-17-1917</b>	9. AGE (In years last birthday) <b>51</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Optometrist</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Optical Industry</b>		11. BIRTHPLACE (State or foreign country) <b>Rhode Island</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Frank Galiano</b>			
14. MOTHER'S MAIDEN NAME <b>Mary DiLugli</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs Jennie M. Galiano Same as # E</b>			
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic heart disease</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>1 day</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>3 years</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>420.1 II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 1968</b> to <b>August 15 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 15 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Max J Miller M.D.</b>				23B. DATE SIGNED <b>8/15/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>MAX J MILLER M.D.</b>				23D. ADDRESS <b>1047 INGLETSIDE AVE BALT. 21228 MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-19-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral</b>	
24D. LOCATION (City, town, or county) <b>Balto., Md.</b>		24E. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>			
25A. DATE RECD BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Tarkenton</b>		25C. FUNERAL DIRECTOR <b>Win Cook-Brooks West, 6212 Balto. Nat'l Pike Balto., Md.</b>	

7-11-9

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# FUNERAL DIRECTOR: IMPORTANT

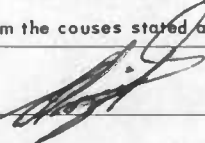
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

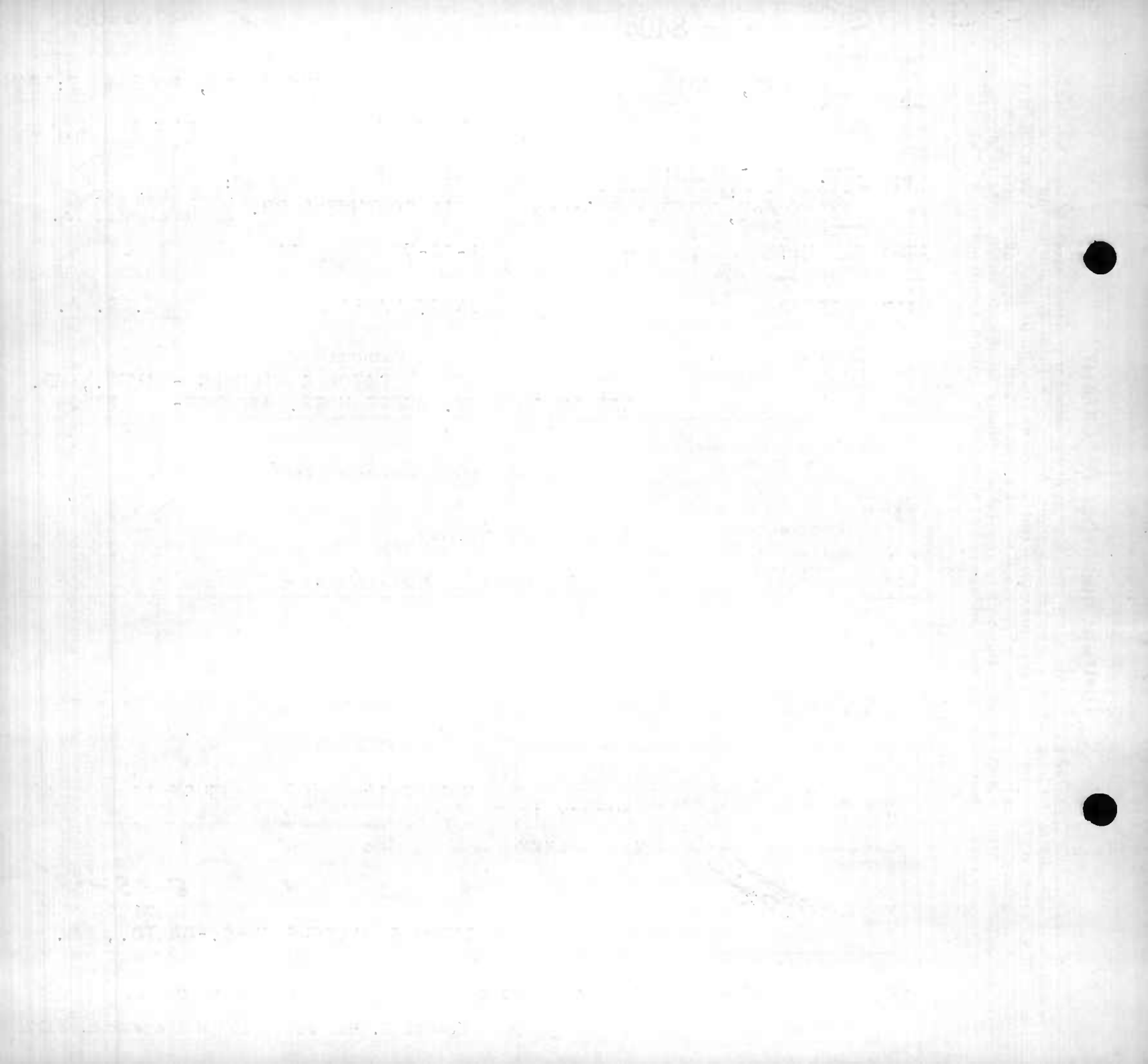
BIRTH NO. 68-8407				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-8407	
1. NAME OF DECEASED (Type or Print) <b>Dziur, MR TOMAS</b>				2. DATE AND HOUR OF DEATH <b>8-17-68</b> <b>2:30</b> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Bon Secours Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>20-02</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>34 Bon Secours Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE, Maryland</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>2112 W. BALTO. ST.</b>		F. CITY OR TOWN <b>BALTIMORE, Maryland</b>		G. DATE OF BIRTH <b>8-2-91</b>		H. AGE (In years last birthday) <b>71 yrs</b>	
I. SEX <b>M</b>		J. RACE <b>W</b>		K. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		L. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
M. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		N. KIND OF BUSINESS OR INDUSTRY		O. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>		P. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
Q. FATHER'S NAME <b>George Dziur</b>				R. MOTHER'S MAIDEN NAME <b>PATRONE</b>			
S. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO NO</b>		T. SOCIAL SECURITY NO. <b>219-30-6066A</b>		U. INFORMANT <b>Hospital Records</b>		V. ADDRESS	
W. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>1620.1</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Ca. lung</b>				X. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Y. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>163X II</b> <b>Other significant conditions contributing to the death but not related to the terminal disease or condition given in part 1 (A).</b>				Z. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Progressive ca of lung</b>			
AA. DUE TO, OR AS A CONSEQUENCE OF: <b>ca of lung</b>				BB. DUE TO, OR AS A CONSEQUENCE OF:			
CC. DUE TO, OR AS A CONSEQUENCE OF:				DD. DUE TO, OR AS A CONSEQUENCE OF:			
EE. DUE TO, OR AS A CONSEQUENCE OF:				FF. DUE TO, OR AS A CONSEQUENCE OF:			
GG. DUE TO, OR AS A CONSEQUENCE OF:				HH. DUE TO, OR AS A CONSEQUENCE OF:			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				JJ. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		21G. HOW DID INJURY OCCUR?		21H. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-8-1968</b> to <b>8-17-1968</b> , that (I) (we) last saw the deceased alive on <b>8-16-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did) (did not) view the body after death.							
23A. SIGNATURE <b>MAKIPPOOR</b>				23B. DATE SIGNED <b>8-17-68</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. MAKIPPOOR</b>	
23D. ADDRESS <b>BON-SECOURS HOSPITAL</b>				23E. ADDRESS		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/20/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Louisa PARK Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Thomas J. Kennedy</b>		25D. ADDRESS <b>1000 N. Park St</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
68- 8408				68- 8408	
BIRTH NO.				2	
1. NAME OF DECEASED (Type or Print) <b>CAMMER, MARIE</b>				2. DATE AND HOUR OF DEATH <b>AUGUST 15, 1968 7:10AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>9.9.C. 21090 52-00</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 ST. AGNES HOSPITAL CATON &amp; WILKENS AVES. BALTIMORE, MARYLAND 21229</b>				C. CITY OR TOWN <b>LINTHICUM</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>also: 5412 Saul Street 512 SOUTHWELL RD. Philadelphia, Pa.</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>03-31-95</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HAIR DRESSER</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>Unknown</b>		
14. MOTHER'S MAIDEN NAME <b>Unknown</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <b>204 20 3606</b>			17. INFORMANT <b>CATON &amp; WILKENS - BALTO., MD. ST. AGNES HOSP. RECORDS- 21229</b>		
18. <b>436.0 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) IMMEDIATE CAUSE Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) Hypertension DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) Generalized Atherosclerosis -</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>331X II</b>					
21A. DATE OF OPERATION <b>0</b>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21C. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>AUGUST 14 19 68</b> to <b>AUGUST 15 19 68</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>AUGUST 15 19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED <b>8-15-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Howard H. Hubbard</b>				23D. ADDRESS <b>21229 CATON &amp; WILKENS AVES.-BALTO., MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-20-68</b>		24C. NAME of CEMETERY or CREMATORY <b>Hillside Cemetery</b>	
24D. LOCATION <b>Philadelphia, Penna.</b>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>	



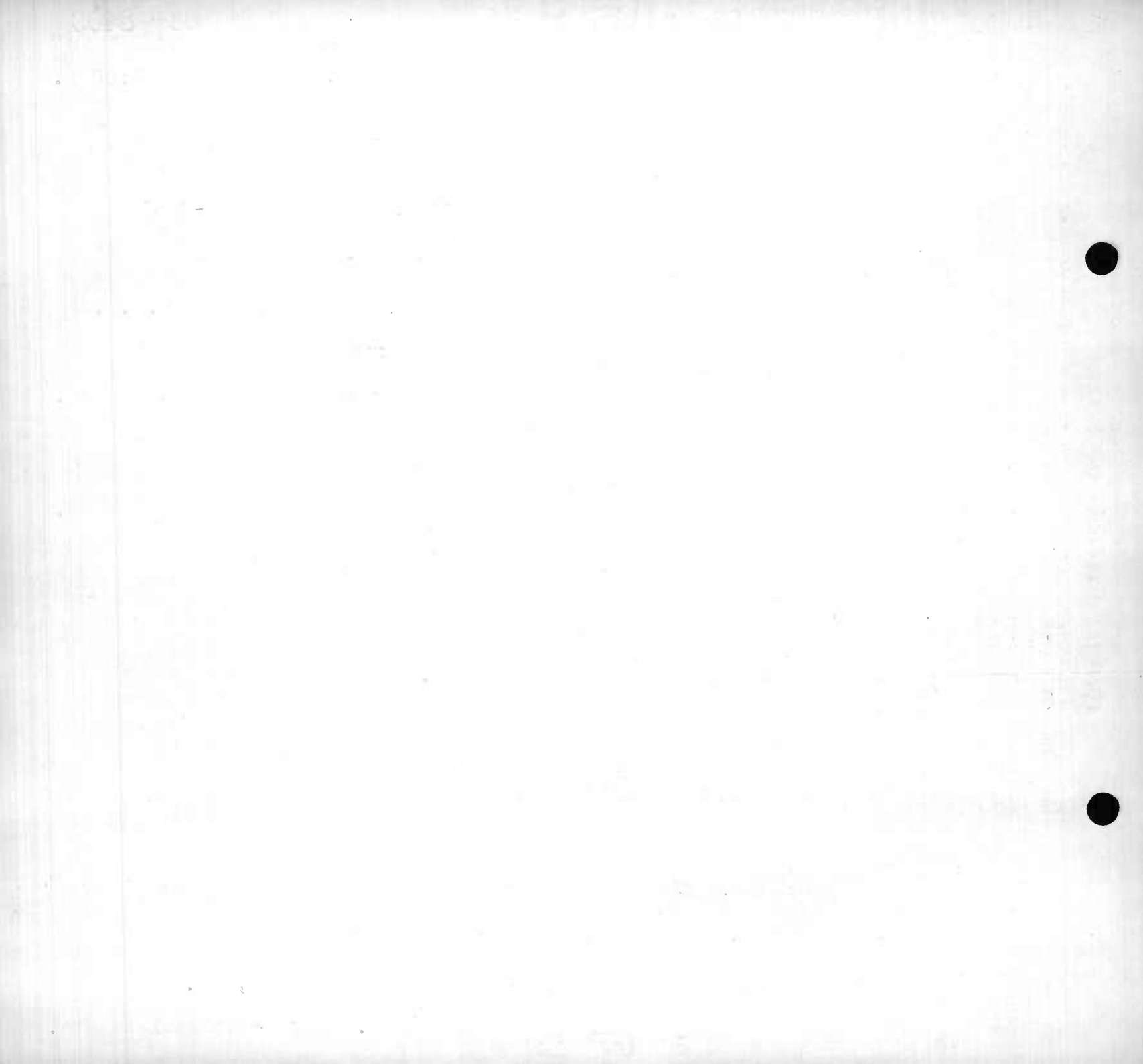
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8409

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 8409

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Alice Eppers		2. DATE AND HOUR OF DEATH August 15, 1968 7:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hospital Baltimore, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3653 Chestnut Avenue - 3653		
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan, 16, 1915	9. AGE (In years last birthday) 53	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Kane		14. MOTHER'S MAIDEN NAME Martha <del>Nix</del> Meeks	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Wayne Eppers ADDRESS as above ad.	
18. 199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Intestinal Obstruction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Metastatic Carcinoma			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. 199.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION Aug. 4, 1968		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruction		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 30 19 68 to August 15 19 68, that (I) (we) lost saw the deceased alive on August 15 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Consolador C. Palad, Jr.</i>				23B. DATE SIGNED August 15, 1968	
23C. PHYSICIAN'S NAME (Type) Consolador C. Palad, Jr., M.D.		23D. ADDRESS Maryland General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/19/68		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 19 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Austin E. Donovan - 3818 Roland Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 8410 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 8410

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Catherine E. Blackburn.

2. DATE AND HOUR OF DEATH

August 14, 1968

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

38

University Hospital.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Md.

C. CITY OR TOWN

Baltimore.

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

807 Woodward St.

5. SEX

Female

6. RACE

White.

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

April 5, 1908

9. AGE (In years  
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Saleslady.

10B. KIND OF BUSINESS OR INDUSTRY

Dept. Store.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

217-09-6276

17. INFORMANT

ADDRESS

Jesse N. Blackburn Jr. 8362 Pulaski Highway.

18. 404 X I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, osthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

*Hypertensive Cardio Renal  
disease*

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

5 yrs.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

442X II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐

Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1940 to Aug 14, 1968,  
that (I) (we) last saw the deceased alive on Aug. 1967 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did not) view the body after death.

23A. SIGNATURE

*Alfred Schrecker*

DEGREE

Attending  
Phys. ☒

Med.  
Director ☐

Staff  
Phys. ☐

23B. DATE SIGNED

8-16-68

23C. PHYSICIAN'S  
NAME (Type)

MORRIS E. SCHREIBER

DEGREE

23D. ADDRESS

1579 W. Lombard St. Baltimore Md.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

Aug 17, 1968

24C. NAME OF CEMETERY or CREMATORY

Woodlawn

24D. LOCATION

Balto. Co

25A. DATE REC'D BY HEALTH DEPT.

AUG 19 1968

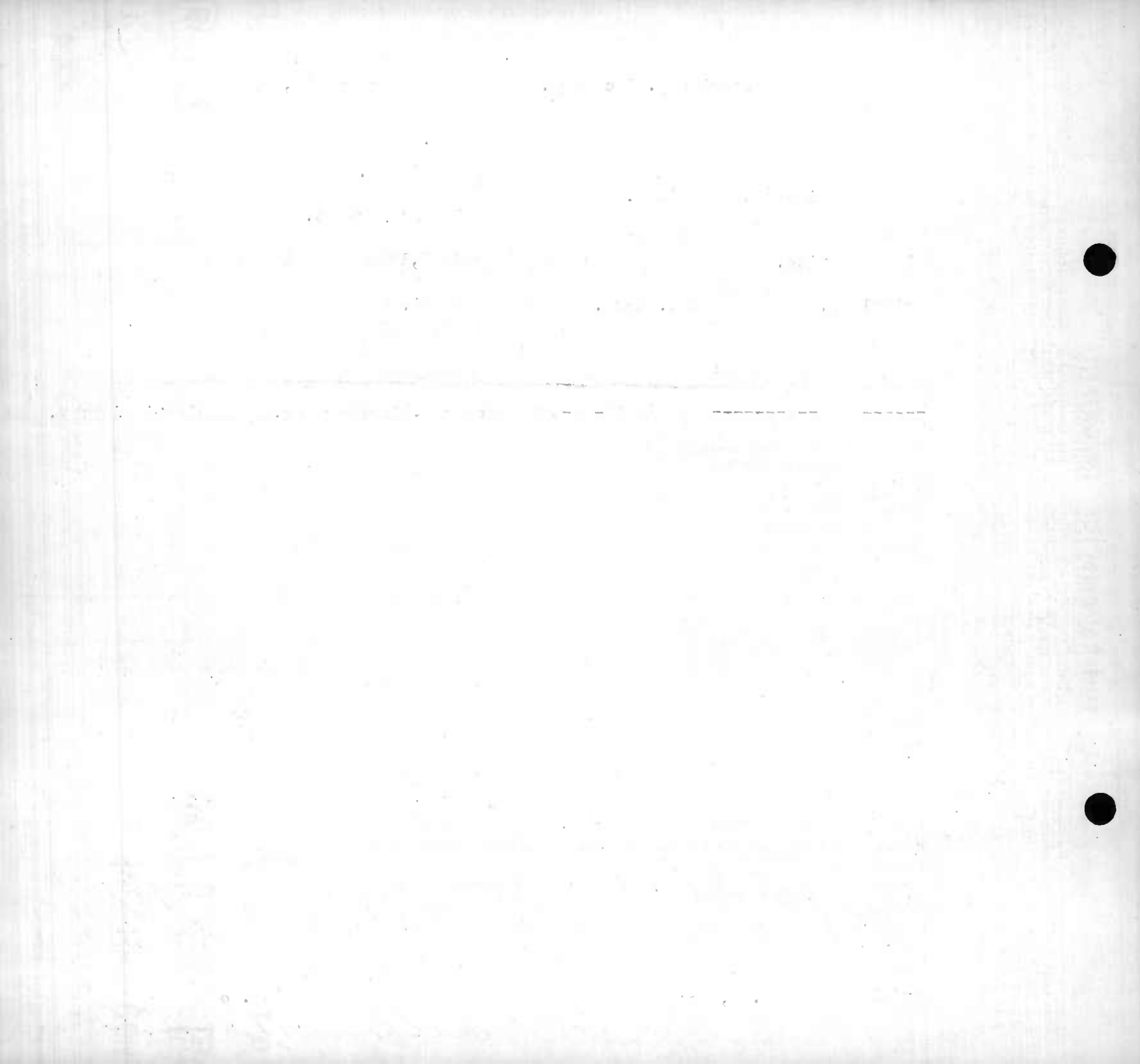
25B. NAME OF REGISTRAR

Robert E. Sisk

25C. FUNERAL DIRECTOR

Paul E. Schrecker

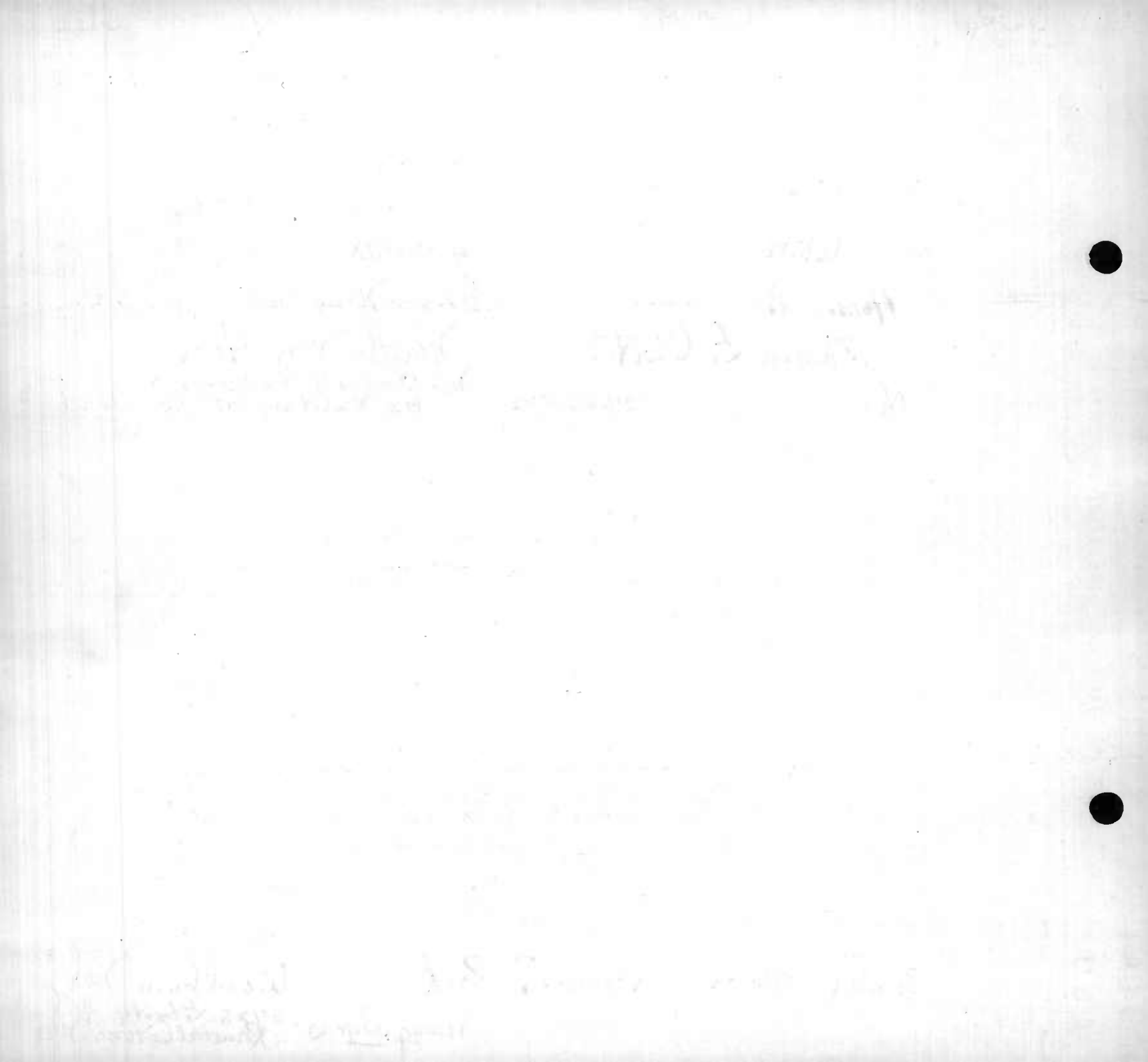
ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

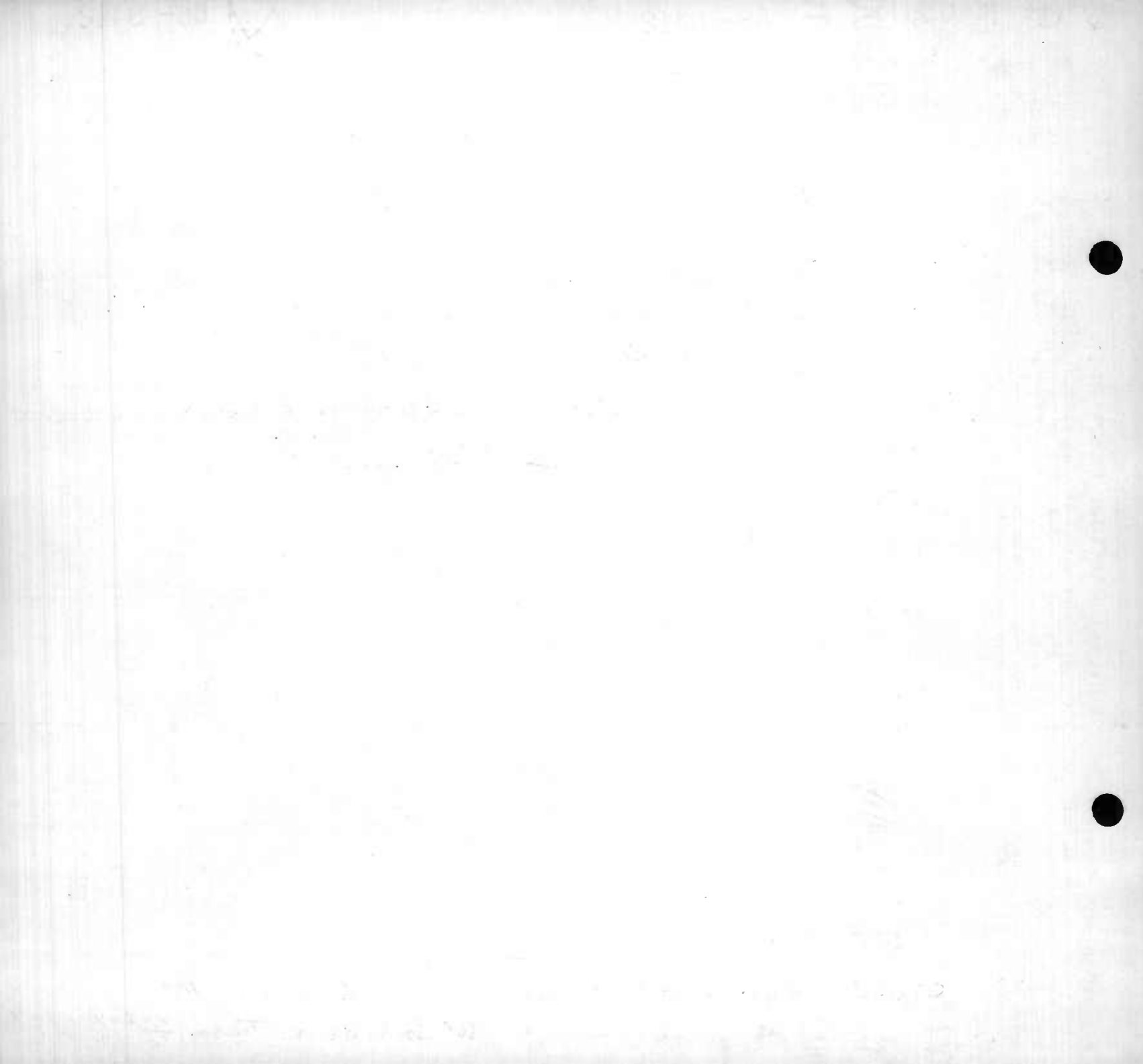
BIRTH NO. 68- 8411				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 8411	
1. NAME OF DECEASED (Type or Print) <b>Haddaway, Hester C.</b>				2. DATE AND HOUR OF DEATH <b>August 13, 68 12:20 P M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Sinai Hospital of Baltimore</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b> <b>53.00</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Sinai Hospital of Baltimore</b>				C. CITY OR TOWN <b>Pikesville</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>618 Military Ave. 21208</b>			
5. SEX <b>FM</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-28-1908</b>		9. AGE (In years lost birthday) <b>60</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <b>Glencoe, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Hamon L. Curtis</b>			14. MOTHER'S MAIDEN NAME <b>Martha Mae Hoover</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>			16. SOCIAL SECURITY NO. <b>216-48-4302</b>		17. INFORMANT <b>Mrs. Charles H. Haddaway Sr. 21208</b> <b>618 Military Ave. Pikesville MD</b>		
18. <b>183.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Shock</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>Ca of Ovary with metastatic</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
175.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>None</b>							
19A. DATE OF OPERATION <b>1964</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cancer of Ovary</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>No Injury</b>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>No Injury</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>Aug 1 19 68</b> to <b>Aug 13 1968</b> , that (I) (we) last saw the deceased alive on <b>8/13/68 12:20 PM</b> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>[Signature]</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>8/13/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>[Signature]</b>				23D. ADDRESS <b>Sinai Hosp of Baltimore</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8/16/68</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Lothman Park</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn. MD</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR <b>Lois B. [Signature]</b> <b>8728 Liberty Rd Randallstown. MD</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8412	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ANNA C. BROWN</b>		2. DATE AND HOUR OF DEATH <b>8/15/68 3.50 p. m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>48 MARYLAND GENERAL HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>810 BEAVERBANK CIRCLE</b>		
5. SEX <b>F.</b>	6. RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>2/16/85</b>	9. AGE (In years lost birthday) <b>83</b>	If Under 1 Yr. Months: Oays: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>BERNARD ROFFER</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>			16. SOCIAL SECURITY NO. <b>21554 200J1</b>		17. INFORMANT <b>MRS BRITANNIA B Riggs - OWINGS, MILLS MD</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>783.1 I</b> <b>PULMONARY HYPERTENSION</b> <b>CAUSE OF DEATH</b> <b>IMMEDIATE CAUSE</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>CARCINOMA RECTUM.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>783.1 II</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>DELFA C. GOMEZ, M.D.</b>				23B. DATE SIGNED <b>8/15/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>DELFA C. GOMEZ</b>		23D. ADDRESS <b>HOSP.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>AUG 19, 1968</b>	24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkner</b>		25C. FUNERAL DIRECTOR <b>W. Cook - Brooks</b>	
				ADDRESS <b>1050 York Rd Towson Md</b>	



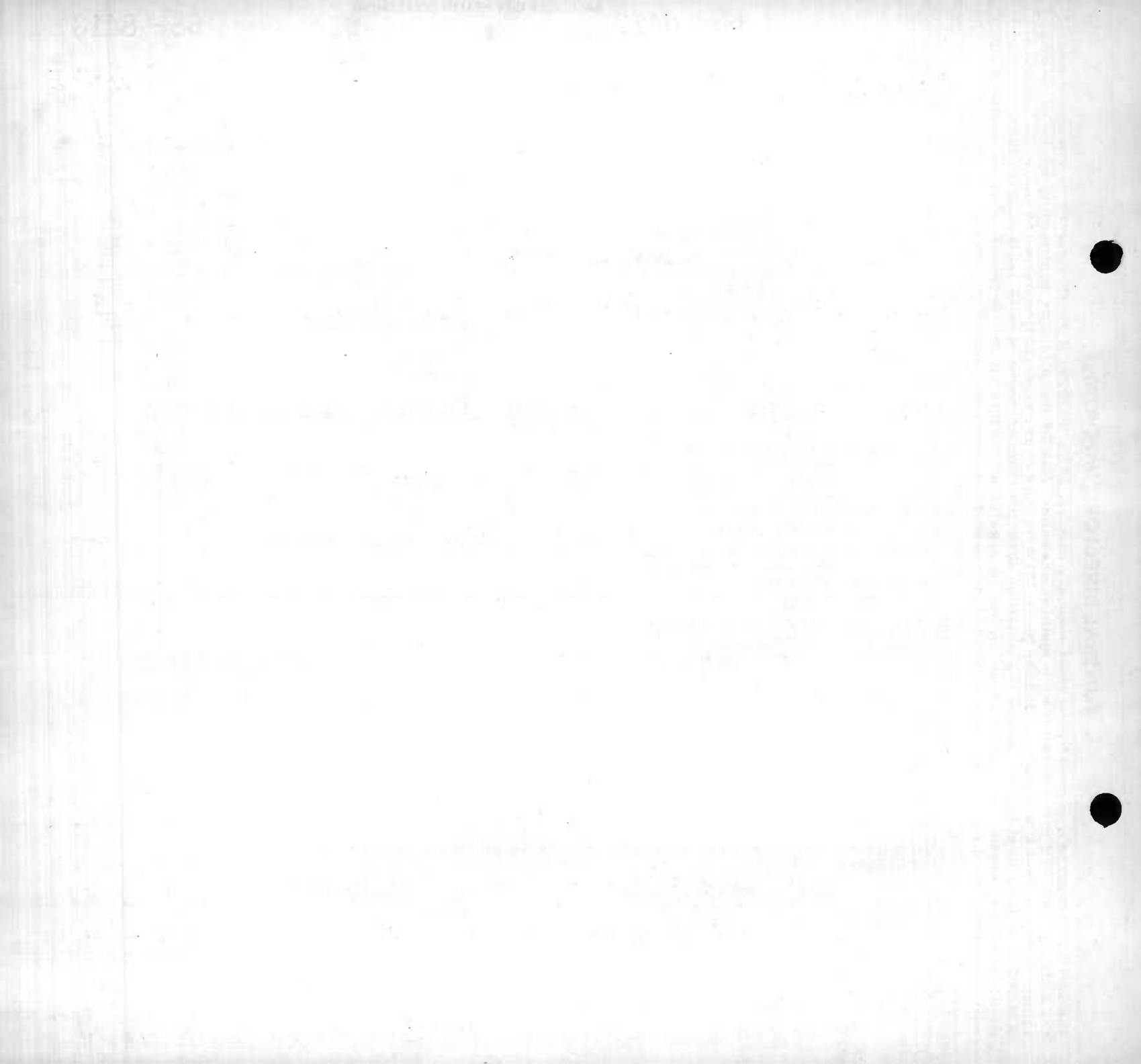
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8413 CERTIFICATE OF DEATH

REG. NO. 68- 8413

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Arthur William A. Shields</b>		2. DATE AND HOUR OF DEATH <b>8-14-68 @ 11:00 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>11-01</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Bolton Hill Hosp. &amp; Convalescent Home</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baets.</b>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>815 N. Calvert St. 21202</b>	
5. SEX <b>Male</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3-17-93</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rentologist</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Enoch Pratt Library</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>	
13. FATHER'S NAME <b>Patrick Thomas P. Shields</b>		14. MOTHER'S MAIDEN NAME <b>Mary Akin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W.II</b>		16. SOCIAL SECURITY NO. <b>217-09-5161A</b>		17. INFORMANT <b>Donald G. Shields</b>	
18. <b>440.91</b>		CAUSE OF DEATH		ADDRESS <b>2105 Starmount Lane - Eutherville, Md.</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>coronary heart failure with</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(B) <b>arteriosclerosis generalized</b>		<b>years</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>45-0.0 II</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>2/14</b> 19 <b>68</b> to <b>8/14</b> 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>8/14</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>ALLAN H. MACINTYRE MD</b>				23B. DATE SIGNED <b>8/14/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALLAN H. MACINTYRE MD</b>		23D. ADDRESS <b>2 E READ ST BALTIMORE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-17-68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>	
24D. LOCATION <b>Cockeysville Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson</b>		25D. ADDRESS <b>1050 York Rd Towson, Md 21204</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
68- 8414		68- 8414		68- 8414	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		George Neyer		8-14-68 5:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
Union Memorial Hosp.		Maryland		Baltimore	
15. SEX		16. RACE		17. MARRIED, NEVER MARRIED	
Male		White		WIDOWED, DIVORCED (specify)	
18. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		19. KIND OF BUSINESS OR INDUSTRY		20. DATE OF BIRTH	
retired				12-25-1900 68	
21. BIRTHPLACE (State or foreign country)		22. CITIZEN OF WHAT COUNTRY?		23. AGE (In years last birthday)	
Pennsylvania		U.S.A.		68	
24. FATHER'S NAME		25. MOTHER'S MAIDEN NAME		26. SOCIAL SECURITY NO.	
Unknown		Unknown		168-14-6616	
27. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		28. INFORMANT		29. ADDRESS	
Yes		Stewart J. Dreisbach F.H.		644 E. GRAND AVE. Tower City, PENNA.	
30. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		31. CAUSE OF DEATH		32. INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		Cerebral Vascular Accident			
33. ANTECEDENT CAUSES		34. DUE TO		35. DUE TO	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
36. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		37. DATE OF OPERATION		38. CONDITION FOR WHICH OPERATION WAS PERFORMED	
331X II		0			
39. DATE OF OPERATION		40. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		41. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8-12 19 68 to 8-14 19 68, that (we) last saw the deceased alive on 8-14 19 68 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
Stephen Goldberger		8-14-68			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. FUNERAL DIRECTOR	
STEPHEN GOLDBERGER		THE UNION MEMORIAL HOSPITAL		1050 York Rd. Towson, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial				Greenwood Cem.	
24D. LOCATION (City, town, or county) (State)		24E. DATE RECEIVED BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Tower City, PENNA.		AUG 19 1968		Robert E. Tankersley	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
				The Cook-Brooks Inc.	

George M. Jones

1934-1935

1935-1936

Union Memorial High School, Charleston, W. Va.

Male White ~~Married~~ 12-22-1908

Pennsylvania

retired

Unknown

Unknown

Cerebral Vascular Accident

8-14-08

8-15-08

8-14-08

*Robert J. Jones*

STEELER, W. L. D. E. C. E.

THE WHITE HOSPITAL

8-14-08

S-156

68- 8415 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 8415

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>GAIL SWABENER - SWADENER</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>8</b> Day <b>10</b> Year <b>68</b> Hour <b>11:00 a</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OF LOCATION) <b>611 S. Bentalou St. 9-6-68</b>		3. DATE PRONOUNCED DEAD Month <b>August</b> Day <b>10</b> Year <b>1968</b> Hour <b>11:00 a</b> M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>20-05</b>		C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>Male</b>	7. RACE <b>White</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>7-26-1892</b> <b>8-26-1891</b>	10. AGE (In years last birthday) <b>XX 76</b>	If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Glassblower</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>??????</b>	
15. MOTHER'S MAIDEN NAME <b>Lillie Hamilton</b>		18. INFORMANT <b>Schmidt + Dhonau Funeral Home, Reading, Ohio</b>	
19. <b>412.4 SS# 212-10-6077</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>422.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>August 11, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>XXXXX Burial</b>		24B. DATE <b>8-14-1968</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Oakhill Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Springdale, Ohio</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>	
25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks, Inc., Balto., Md. 21204</b>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPT. 68- 8416 CERTIFICATE OF DEATH

REG. NO. 68- 8416

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JONES IRVING C.</b>		2. DATE AND HOUR OF DEATH <b>August 13, 1968 10<sup>15</sup> AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>3207 Clearview Ave.</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>08-01-12</b>	9. AGE (In years last birthday) <b>56</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Oiler</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>American Can Co.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>		13. FATHER'S NAME <b>UNKNOWN - Alnozo Jones</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN Elizabeth Stockman</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-12-8481</b>		17. INFORMANT ADDRESS <b>Mrs. Alno C. Lilley - 3207 Clearview Ave.</b>	
18. <b>410.9 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Ventricular aneurysm.</b> <b>Branchopneumonia bilateral.</b> <b>Y.S.</b>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>420.1 II</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(he)</del> (this hospital) attended the deceased from <b>7/18</b> 19 <b>68</b> to <b>8/13</b> 19 <b>68</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>8/13</b> 19 <b>68</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <b>Ricardo Mori</b>				23B. DATE SIGNED <b>8/13/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>RICARDO MORI M.D.</b>				23D. ADDRESS <b>UNION MEMORIAL Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-16-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland-21206</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR ADDRESS <b>John C. Miller Inc-6415 Belair Rd.-21206</b>			

301 (MAY 1980)

08-01-11 23

X

MAILED  
OUTSIDE

OUTSIDE

Acute respiratory infection

Diagnosis: Influenza  
Treatment: Supportive

Y.2

Yes

8/13

7/12/80

8/13

8/13

MAILED

OUTSIDE

MAILED

OUTSIDE

*[Signature]*

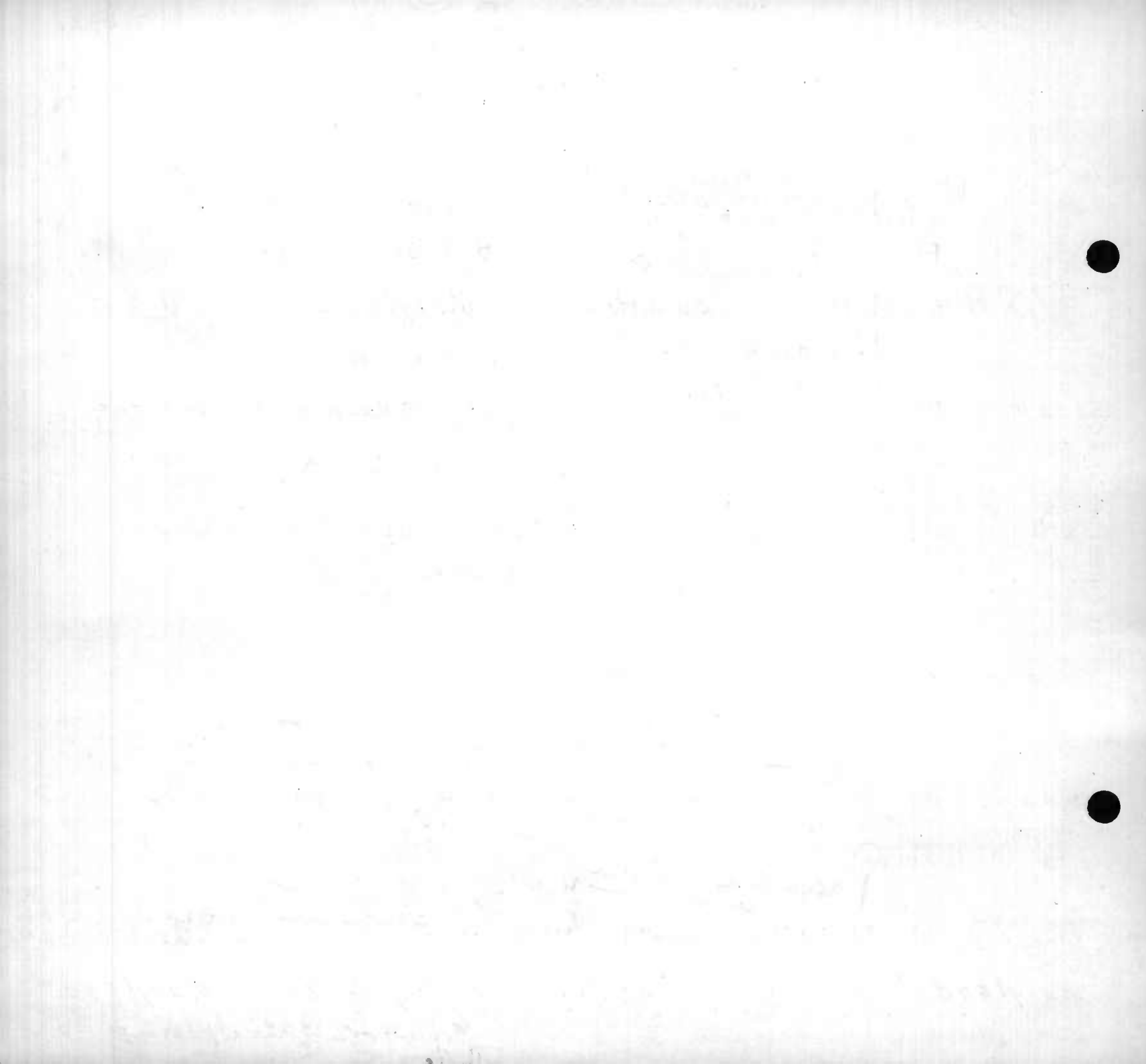
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 68- 8417 CERTIFICATE OF DEATH

REG. NO. 68- 8417

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ALICE V. SNYDER.		8.15.68 11.15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
LUTHERAN HOSPITAL OF MD. 730 ASHBURTON STREET, BALTO. MD. 21206				MARYLAND 15-11	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				3520 N. Hilton Rd.	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
F	W.	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8.7.96	71 YRS.	U.S.A
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		own Home		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Unknown			Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No					Maryr. Johnson 2146 Wicks Ave
18. 412.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES				URAEMIA	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the underlying condition lost.				(B) ARTERIOSCLEROTIC CARDIO- DUE TO, OR AS A CONSEQUENCE OF:	
				-VASCULAR DISEASE.	
19. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8.2.1968 to 8.15.1968, that (I) (we) lost saw the deceased alive on 8.15.1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE					23B. DATE SIGNED
DR. PRATIBHA JOSHI M.B.B.S.					
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS
DR. PRATIBHA JOSHI M.B.B.S.					Lutheran Hospital of Md. 730 Ashburton Street Balto. Md.
24A. REMOVAL CEMETERY	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	8/19/68	New Cathedral Cemetery Baltimore Maryland		212	
25A. DATE RECEIVED	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
AUG 19 1968	Robert E. Stebbins	Ambrose J. Igo 1328 Sulphur Sp. Rd.			

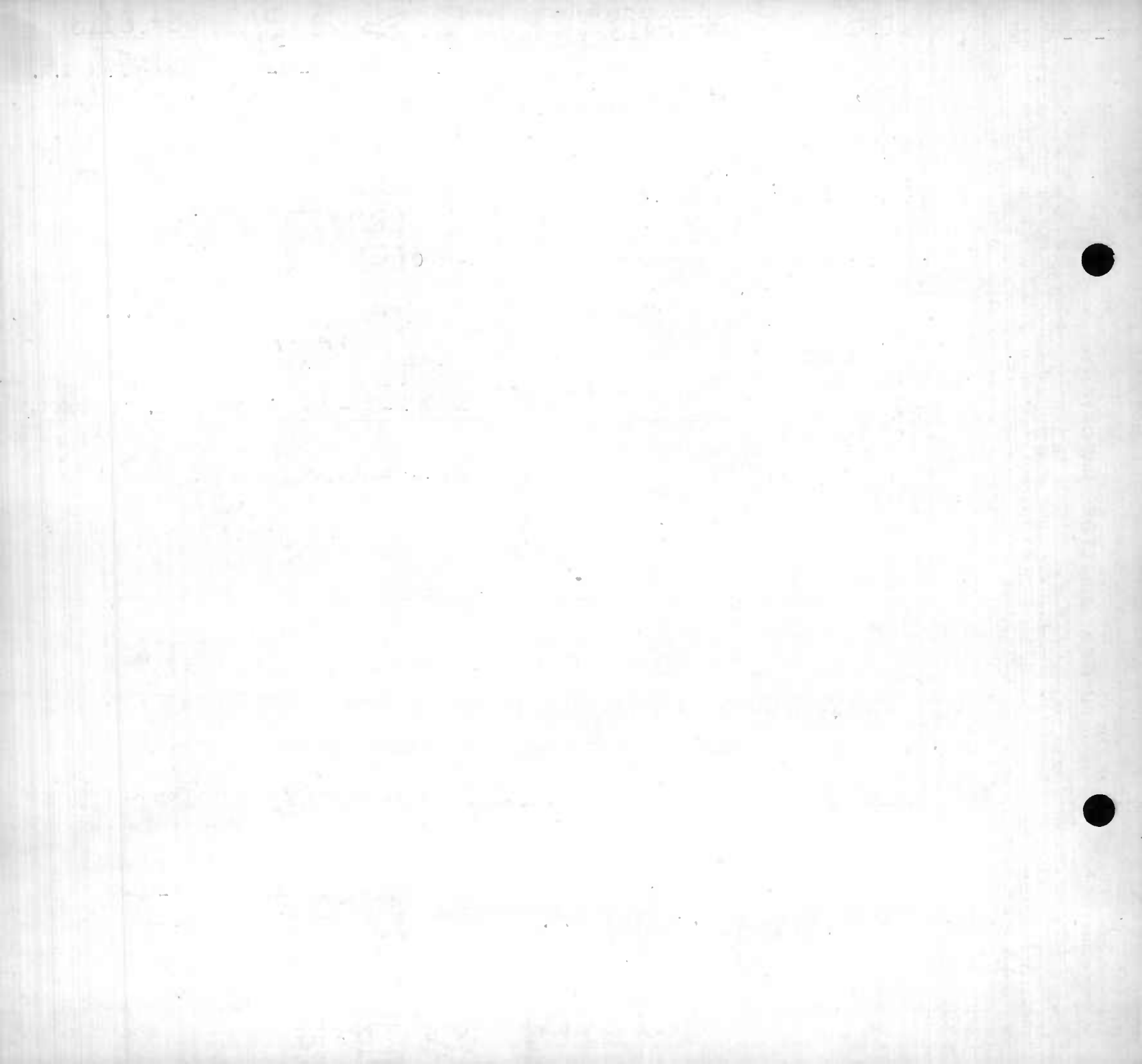


52-37-76 1B

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-200		68-8418		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-8418	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>PUGH, Clifton</b>			
2. DATE AND HOUR OF DEATH <b>8-14-68 4:40 P.M.</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224</b>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland, Baltimore Co.</b> B. COUNTY <b>ESSEX</b>				5. CITY OR TOWN <b>ESSEX</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER <b>405 Delaware Ave #21221</b>				6. SEX <b>Male</b> 7. RACE <b>White</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. AGE (In years last birthday) <b>59</b>				10. DATE OF BIRTH <b>7-30-09</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Samuel</b>				14. MOTHER'S MAIDEN NAME <b>Susan STERLING</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNK</b>				16. SOCIAL SECURITY NO. <b>213-07-7087</b>			
17. INFORMANT <b>RECORDS-BCH-4940 Eastern Ave. Baltimore, Md</b>				ADDRESS			
18. <b>412.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL INFARCTION / OR MASSIVE PULM EMBOLUS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CONG. HT. FAILURE</b> <b>ATHEROSCLEROTIC HT. DISEASE</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 HRS</b> <b>? The</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>430.0 II</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8-10</b> 19 <b>68</b> to <b>8-14</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8-14</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Lee J Cordova M.D.</b>				23B. DATE SIGNED <b>8-14-68</b>			
23C. PHYSICIAN'S NAME (Type) <b>LEE J. CORDOVA M.D.</b>				23D. ADDRESS <b>Baltimore City Hospitals 4940 Eastern Ave #21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/17/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>OAK LAWN</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. M.D.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. [unclear]</b>		25C. FUNERAL DIRECTOR <b>G. B. CONNELLY SONS</b>		ADDRESS <b>300 MACE</b>	



W-2134

68- 8419 BALTIMORE CITY HEALTH DEPARTMENT

68- 8419

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GORDON F WISTLING		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 15, 1968 Hour 6:30 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year August 15, 1968 Hour 6:30 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH NOV. 21, 1915		10. AGE (In years lost birthday) 52 50	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME August WISTLING		14. STREET AND NUMBER 420 Arsan Avenue	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Am Harris Tree Est. - Above		16. KIND OF BUSINESS OR INDUSTRY	
17. MOTHER'S MAIDEN NAME Anna Wiener		18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
19. SOCIAL SECURITY NO. 217-10-8257		20. INFORMANT Family	
21. ADDRESS Some		22. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Craniocerebral Injuries	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? In front of 2466 Greenmount Avenue	
22D. TIME (Month) (Day) (Year) (Hour) August 10, 1968 2:00A		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Found on street		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <u>Ronald N. Kornblum</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-20-68	
24C. NAME OF CEMETERY or CREMATORY Balto. National Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 19 1968		25B. NAME OF REGISTRAR Robert E. [Signature]	
25C. FUNERAL DIRECTOR [Signature]		ADDRESS 4200 Pennington Ave (24)	

WATERLOO  
JAN 11 1862  
RECEIVED  
OFFICE  
OF THE  
ATTORNEY  
GENERAL  
STATE OF NEW YORK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-652 68-8420 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-8420	
1. NAME OF DECEASED (Type or Print) <b>Rosa BERNSTEIN</b>				2. DATE AND HOUR OF DEATH <b>8-15-68 12.10 P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LEVINDALE HEBREW HOME &amp; INF. Belvedere at Greenspring Ave 21215</b>				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>YES</b>	
E. STREET AND NUMBER <b>4803 BEAUFORT AVENUE</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-5-6</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>ELIJA SCHWARTZ</b>				14. MOTHER'S MAIDEN NAME <b>ESTHER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>MR. I. A. BERNSTEIN, ANN ARBOR, MICH. 48103</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>410.9 I Myocardial Infarct minutes</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD years</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>420.1 II</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Nat White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>2-25-1962</b> to <b>8-15-68</b> , that (I) (we) last saw the deceased alive on <b>8-15-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ardaiz</b>				23B. DATE SIGNED <b>8-15-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOSE ARDAIZ</b>				23D. ADDRESS <b>7 Oberlin Court, Towson, Md 21204</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-16-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>OHEL YAKOV</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Paul E. Johnson</b>		25C. FUNERAL DIRECTOR <b>SQL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	

Handwritten notes at the top of the page, including the date "1941" and various illegible scribbles.

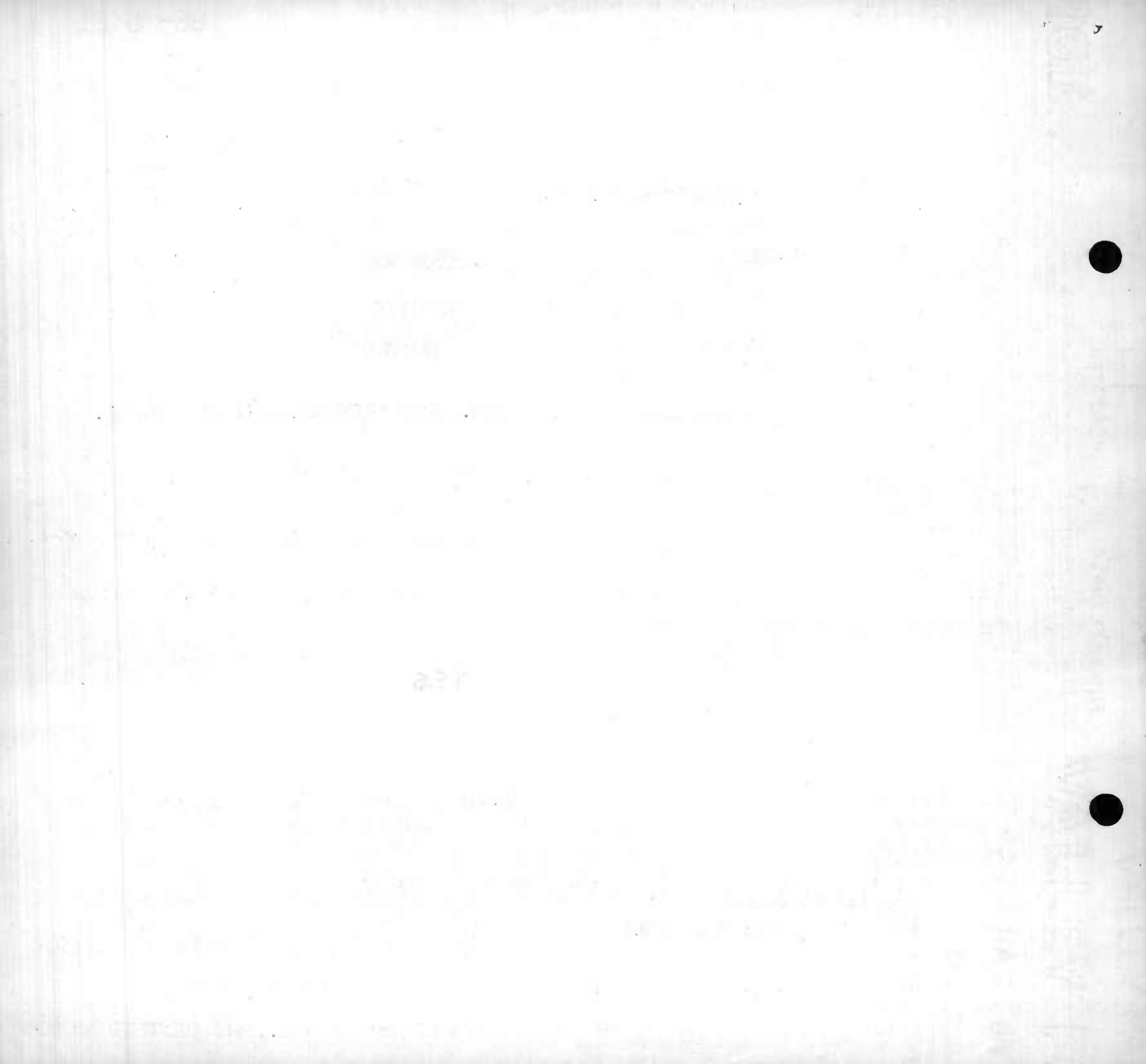
Handwritten word, possibly "Good".

Handwritten text at the bottom right, possibly "THE ARABIS".

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

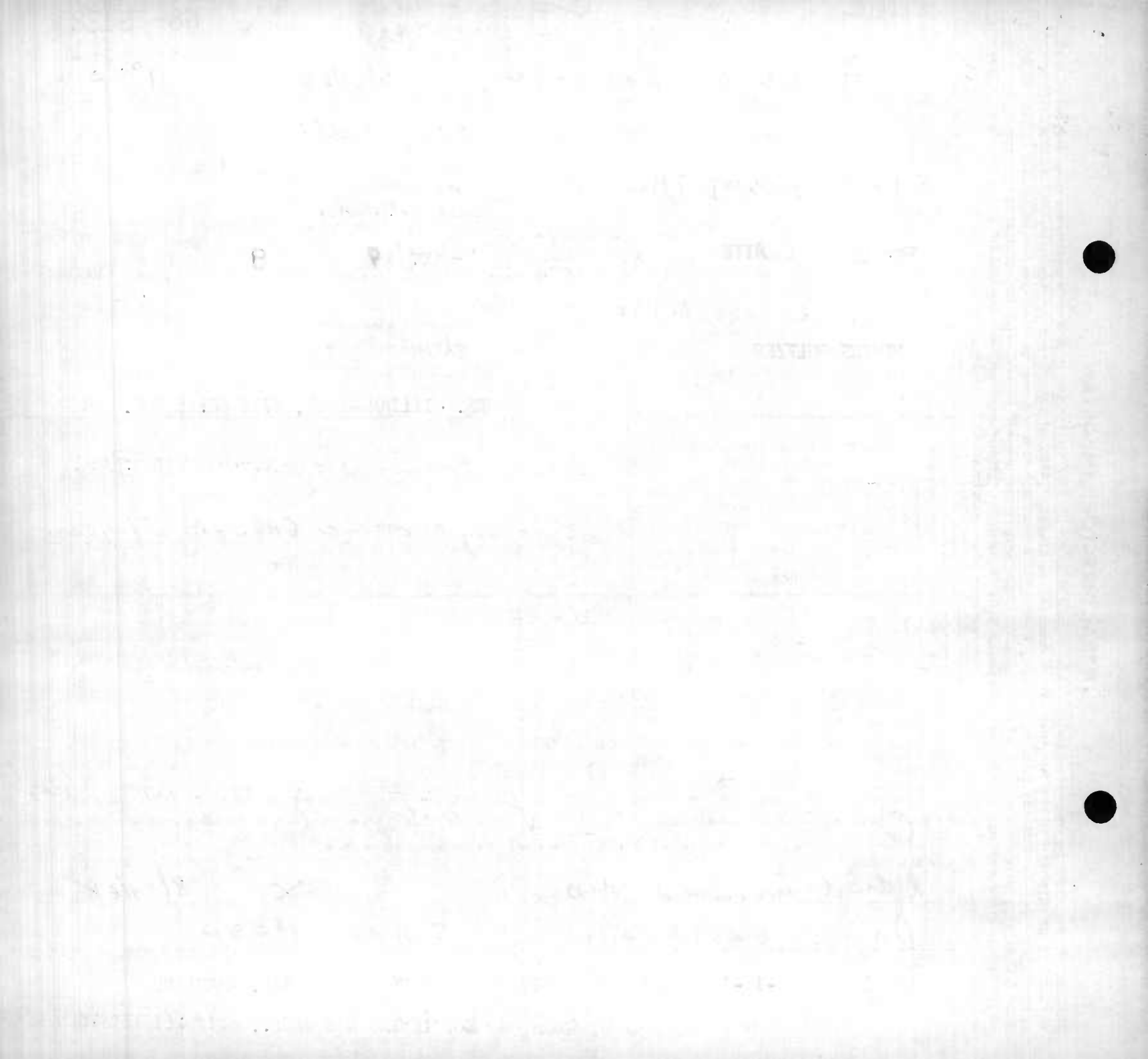
F-635		68- 8421		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 8421	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>AUGUSTA FREEDMAN</b>				August 14, 1968 8:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University of Maryland Hospital</b>				A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE-CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				STREET AND NUMBER <b>5901 Highgate dr. 21215</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1901</b>	9. AGE (In years last birthday) <b>66</b>	If Under 1 Yr. Months: <b>11</b> Days: <b>5</b>	If Under 24 Hrs. Hours: <b>5</b> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Philip Baron</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. NORMA MEINSTER, 6011 HIGHGATE DR. #15</b>			
18. <b>3-573.9 I</b>		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hepatic Failure</b> <b>Cerebral edema -</b>				<b>1 month</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>with Ureteral Herniation</b> DUE TO, OR AS A CONSEQUENCE OF:				<b>24 hrs.</b>	
(C) _____							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>3-83X II</b>							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8/12</b> 19 <b>68</b> to <b>8/14</b> 19 <b>68</b> , that <b>1</b> (we) lost saw the deceased alive on <b>August 14</b> 19 <b>68</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Carol Mel Koski MD</b>				23B. DATE SIGNED <b>Aug 14</b>			
23C. PHYSICIAN'S NAME (Type) <b>CAROL MEL KOSKI</b>				23D. ADDRESS <b>University of Maryland Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-16-68</b>		24C. NAME of CEMETERY or CREMATORY <b>BETH TFILOH</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 18 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Talbot</b>		25C. FUNERAL DIRECTOR <b>SOE LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

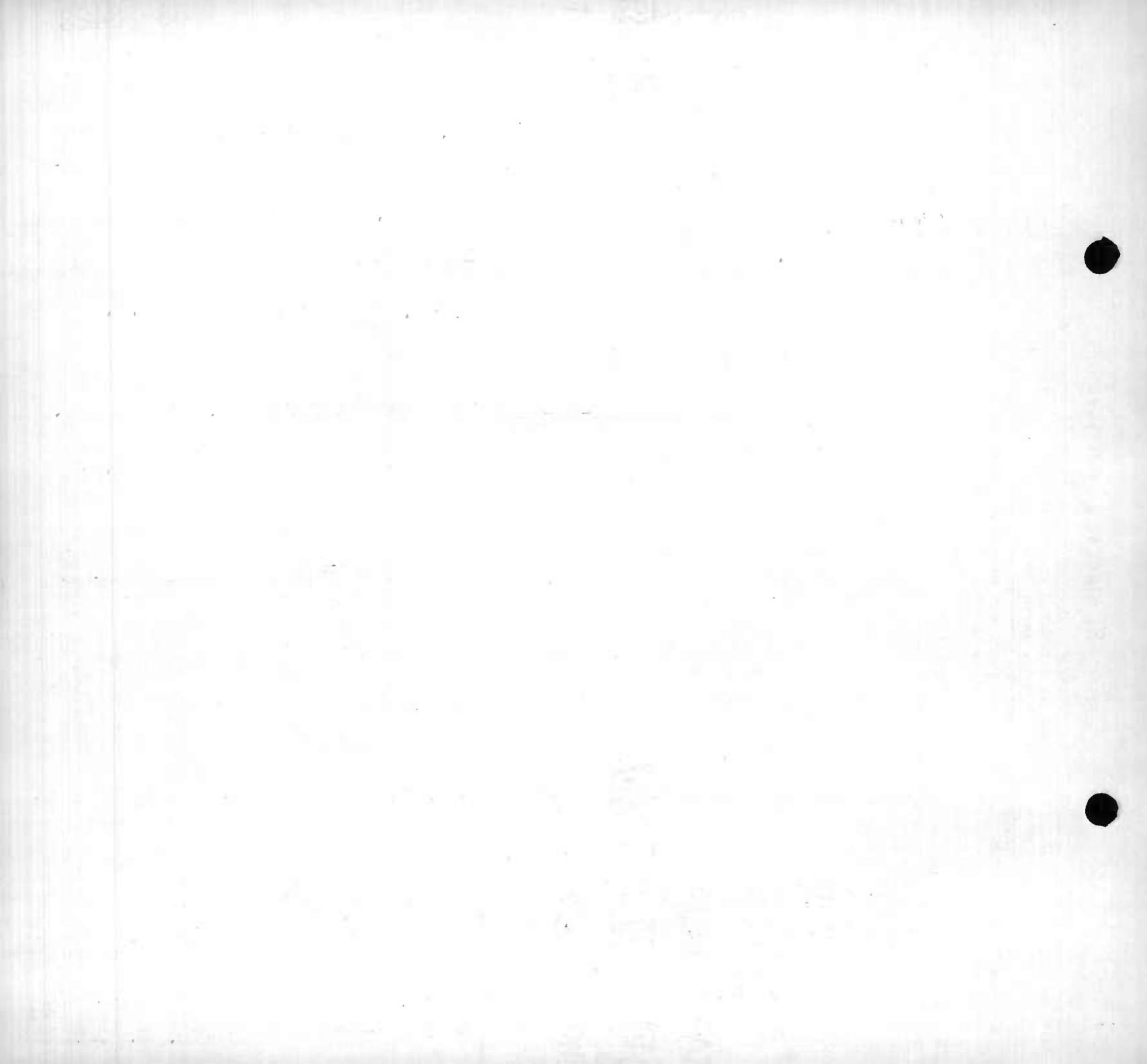
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68- 8422</b>
13-435		68- 8422 CERTIFICATE OF DEATH		
BIRTH NO.				
1. NAME OF DECEASED (Type or Print) <b>TILLIE BOLOTIN</b>		2. DATE AND HOUR OF DEATH <b>8/14/68</b> <span style="float: right;"><b>11<sup>30</sup> P</b></span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL</b> <b>42</b>		A. STATE <b>Md.</b> B. COUNTY <b>Balti</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>4116 Belle Ave</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/22/89</b>	9. AGE (In years lost birthday) <b>79</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>PINCUS GULTZER</b>		14. MOTHER'S MAIDEN NAME <b>SARAH ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. WILLIAM ROSEN, 4114 BELLE AVE. #15</b>
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarction</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Coronary a. disease (ASCAD)</b> (B) <b>7 years</b> (C) <b>none</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3w.</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>420.1 II</b>				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>July 25 1968</b> to <b>Aug 14 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 14 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Daniel Greenwood MD</b>		23B. DATE SIGNED <b>8/14/68</b>		
23C. PHYSICIAN'S NAME (Type) <b>DANIEL GREENWOOD</b>		23D. ADDRESS <b>SINAI HOSP</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-15-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>TIFERETH ISRAEL ANSHE SFARD</b>
24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 18 1968</b>		25B. NAME OF REGISTRAR <b>Robert J. Taylor</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 68- 8423
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Platt, Patrick</b>		2. DATE AND HOUR OF DEATH <b>8/15/68 5:55 P. M.</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI Hospital of Baltimore</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS <b>YES</b> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>5508 N. CHARLES STREET</b>				
5. SEX <b>M</b>	6. RACE <b>CAU.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/11/08</b>	9. AGE (In years last birthday) <b>59</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>	11. BIRTHPLACE (State or foreign country) <b>PHILA. PENN SYLVANIA</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
13. FATHER'S NAME <b>JAMES PLATT (DECEASED)</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN (DECEASED)</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>578-05-8188</b>		17. INFORMANT <b>THERESA PLATT 5508 N. CHARLES ST.</b>
18. <b>412.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Emboli</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>A-S-C-V. disease</b> DUE TO, OR AS A CONSEQUENCE OF: <b>5 years.</b>		
		(C) <b>① Aorto-femoral <del>tub</del> graft</b> <b>1 month.</b>		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>422.1 II</b>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>8/15/68 4:30 PM</b> to <b>8/15/68</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/15/68</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Israel Alvarez</b>		23B. DATE SIGNED <b>8/15/68</b>		23C. PHYSICIAN'S NAME (Type) <b>ISRAEL ALVAREZ M.D.</b>
23D. ADDRESS <b>SINAI HOSP. of BALTIMORE.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>8/20/68</b>	24C. NAME OF CEMETERY or CREMATORY <b>DULANEY VALLEY GARDENS</b>		24D. LOCATION (City, town, or county) (State) <b>TIMOUNIUM MARYLAND</b>
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>John M. Weber</b>		25C. FUNERAL DIRECTOR <b>JOHN M. WEBER &amp; SONS INC. S. CHESTER</b>



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 8424

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>HELEN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> Month Day Year Hour <b>August 16, 1968 6:15 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>2549 Edmondson Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 16, 1968 5:40 P.M.</b>	
6. SEX <b>female</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
7. RACE <b>white</b>		E. STREET AND NUMBER <b>2549 Edmondson Avenue</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. DATE OF BIRTH <b>12/24/95</b>		10. AGE (In years last birthday) <b>72</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maid</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Lord Balto. Hotel</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Kenneth Uhl, 1119 Elm Road, 21227</b>		ADDRESS	
19. CAUSE OF DEATH <b>412.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>A rteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) <b>0</b> <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>8/17/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/20/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>8/18/68</b>		25B. NAME OF REGISTRAR <b>Witzke</b>	
25C. FUNERAL DIRECTOR ADDRESS <b>4101 Edmondson Ave. 21229</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-8425	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <b>DONALD, RUSSELL JOSEPH</b>				2. DATE AND HOUR OF DEATH <b>August 16, 1968 11:55 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Md 21218</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>6728 Brompton Road</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5/12/27</b>	9. AGE (In years last birthday) <b>41</b>	If Under 1 Yr. Months: Oays: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stage Hand</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Theatre</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>	
13. FATHER'S NAME <b>William D. Donald, Sr</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 6/12/44 - 3/12/48</b>		16. SOCIAL SECURITY NO. <b>215-22-1531</b>		17. INFORMANT <b>VA Hospital Records</b> ADDRESS <b>3900 Loch Raven Boulevard, Balto., Md 21218</b>	
18. <b>592X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Chronic renal disease</b> (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>unknown etiology</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>several years</b>	
MEDICAL CERTIFICATION <b>592X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <b>NO</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>h</b> (this hospital) attended the deceased from <b>August 7th 19 68</b> to <b>August 16th 19 68</b> , that <b>h</b> (we) lost saw the deceased alive on <b>August 16th 19 68</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>h</b> (We) (did) <b>did not</b> view the body after death.					
23A. SIGNATURE <b>Susan H. Mather</b>				23B. DATE SIGNED <b>August 16, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>SUSAN H. MATHER, M.D.</b>		23D. ADDRESS <b>Veterans Administration Hospital 3900 Loch Raven Blvd., Balto., Md 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8/19/68</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>R. E. E. Stacey</b>		25C. FUNERAL DIRECTOR <b>Mitzke, 24101 Edmondson Ave., 21229</b>	



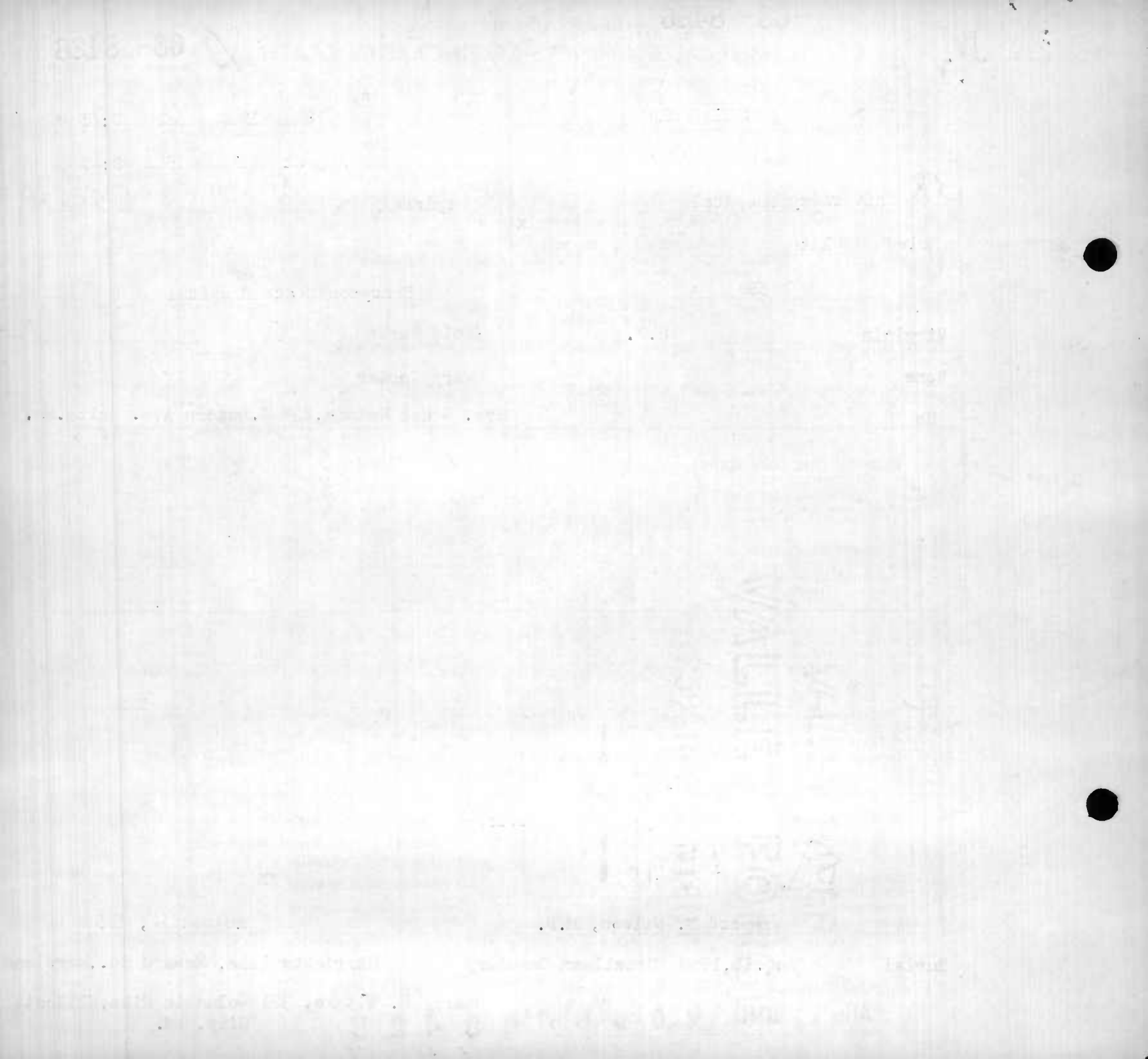
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8426

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ARCHIE PARKS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 13 68 3:45 p M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>University Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 13 1968 3:45 p M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Carroll Co.</b> 56-00	
9. DATE OF BIRTH <b>59</b>		10. AGE (In years last birthday) <b>59</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Mrs. Ethel Nelson</b>		ADDRESS <b>235 N. Luzern Ave. Balto. Md.</b>	
19. <b>485X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Ante mortem pulmonary embolism</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Ante mortem pulmonary embolism</b> (B) <b>Pulmonary embolism</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Ante mortem pulmonary embolism</b> (C) <b>Ante mortem pulmonary embolism</b>	
20A. DATE OF OPERATION <b>7-9-68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <b>2 2 2 2</b>		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) <b>2 2 2 2</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>Unknown</b>		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 16, 1968</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Crestlawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Marriottsville, Howard Co., Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>	
25C. FUNERAL DIRECTOR <b>Harry H. Witzke</b>		ADDRESS <b>321 Columbus Pike, Ellicott City, Md.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8427

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 8427

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ROBERT CHRISTOPHER HILL</b>		2. DATE AND HOUR OF DEATH <b>8/16/68</b>   <b>2<sup>25</sup> AM</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>33 JOHNS HOPKINS HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY C. CITY OR TOWN <b>BALT.</b> D. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1036 BROADWAY</b>		
5. SEX <b>M</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT 1, 1922</b>	9. AGE (In years last birthday) <b>45</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DISABLED VETERAN</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>WILLIAM EMMANUEL HILL</b>		
14. MOTHER'S MAIDEN NAME <b>IDA JOHNSON</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWII</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>SARAH BURTON</b> ADDRESS <b>21 N. FREMONT AVE.</b>		
18. <b>481X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>MENINGITIS, PROBABLY PNEUMOCOCCAL</b> 24 hrs (B) <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF: <b>1 sub</b> (C) _____		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>493X II</b>			ORGANIC HEART DISEASE, ETIOLOGY UNDETERMINED		
19A. DATE OF OPERATION <b>8</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>AUGUST 15, 1968</b> to <b>AUGUST 16, 1968</b> , that (I) <del>was</del> last saw the deceased alive on <b>AUGUST 16, 1968</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) (did not) view the body after death.					
23A. SIGNATURE <b>Michael D. Lutz, M.D.</b>				23B. DATE SIGNED <b>AUGUST 16, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>MICHAEL D. LUTZ, M.D.</b>				23D. ADDRESS <b>DEPT OF MEDICINE, JOHNS HOPKINS HOSP</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/20/68</b>		24C. NAME of CEMETERY or CREMATORY <b>National Cemetery</b>	
24D. LOCATION <b>Baltimore Md</b>		24E. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>			
25A. NAME OF REGISTRAR <b>A. D. J. Johnson</b>		25B. FUNERAL DIRECTOR <b>Adolphus Halstead 1206 W North Ave</b>			

MICHAEL D. LEE, M.D.  
DEPT OF MEDICINE, JOHN HOPKINS HOSPITAL

M.D.

MICHAEL D. LEE, M.D.

August 12, 1961

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101

YES

DISABLED VETERAN

PI

SEP 1, 1942

BALTIMORE, MD

101

JAMES BURTON

101

101

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ARTHUR (O) LANDING</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>August 10, 1968</b> Hour <b>2:00 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 707 W. Lafayette Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 11, 1968 1:50 P.M.</b>	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>12-03</b>	
9. DATE OF BIRTH <b>8/30/85</b>		10. AGE (In years lost birthday) <b>83</b>	
11. BIRTHPLACE (State or foreign country) <b>Chestertown Md</b>		12. CITIZEN OF <b>WHAT COUNTRY?</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>217-05-9788</b>	
18. INFORMANT <b>Mrs Helen Boyd 1411 Division St</b>		ADDRESS	
19. <b>41214</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>8/12/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/15/68</b>	
24C. NAME of CEMETERY or CREMATORY <b>Mt Auburn Cemetry</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Adolphus Halstead</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>1206 W North Ave</b>	

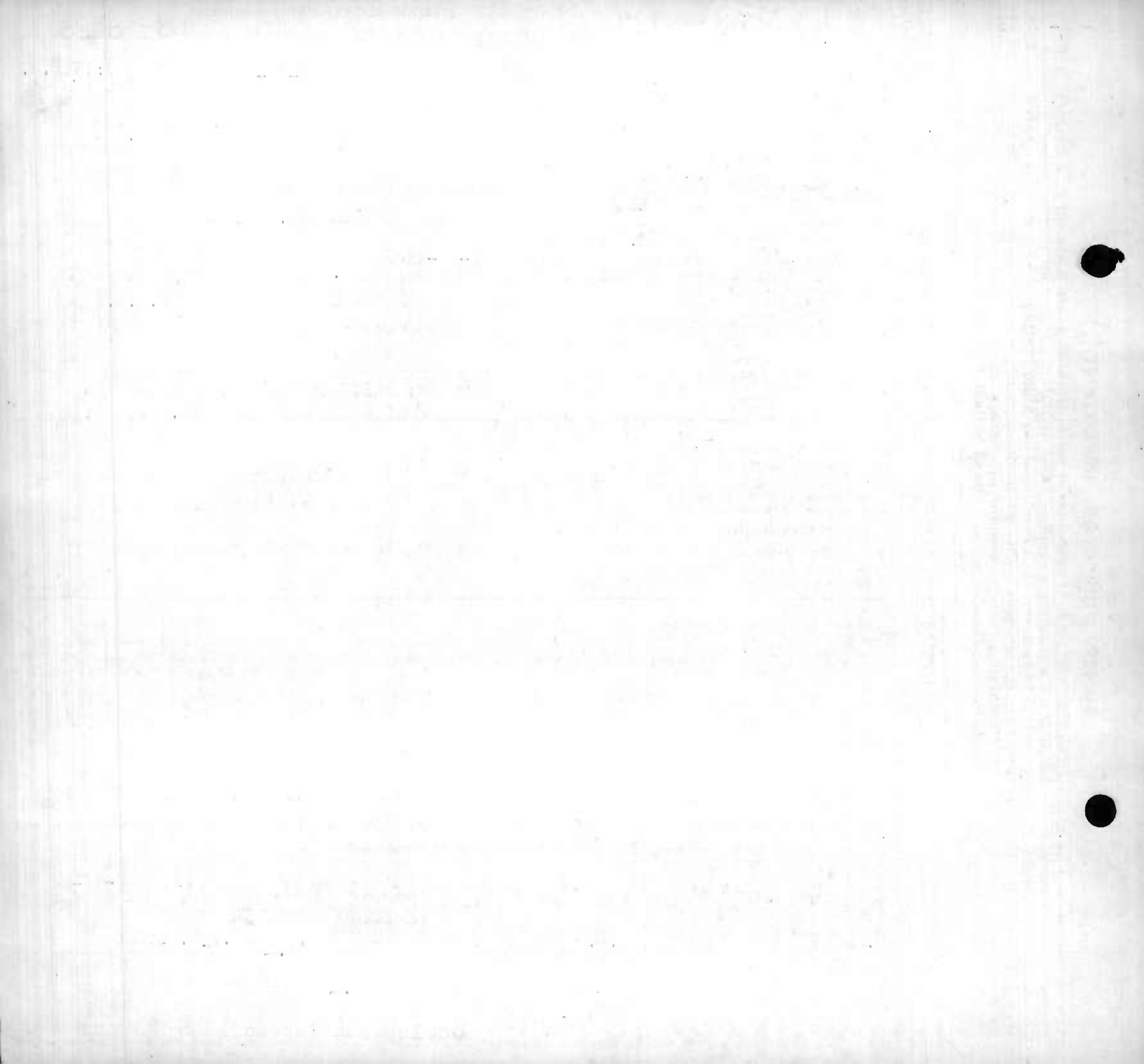
WALLS  
1/2

30-08-34 LB1

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-8429	
<div style="display: flex; justify-content: space-between;"> <span>B-610</span> <span>68-8429</span> <span>CERTIFICATE OF DEATH</span> </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) SARAH BARBEE			2. DATE AND HOUR OF DEATH 8-12-68 7:15 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 31 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 4940 EASTERN AVE., 21224					
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-27-1888	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS RECORDS: BALTIMORE CITY HOSPITALS 4940 EASTERN AVE., BALTO., MD. 21224	
18. CAUSE OF DEATH 486X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 493X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-26-1964 to 8-12-1968, that (I) (we) last saw the deceased alive on 8-12-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Christopher Stuckey				23B. DATE SIGNED 8-12-68	
23C. PHYSICIAN'S NAME (Type) R. CHRISTOPHER STUCKEY, M.D.				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE., BALTO., MD. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/17/68		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery	
24D. LOCATION Baltimore Md		24E. DATE REC'D BY HEALTH DEPT. AUG 19 1968			
25B. NAME OF REGISTRAR Adolphus Halstead		25C. FUNERAL DIRECTOR ADDRESS 1206 W North Ave			



# FUNERAL DIRECTOR: IMPORTANT

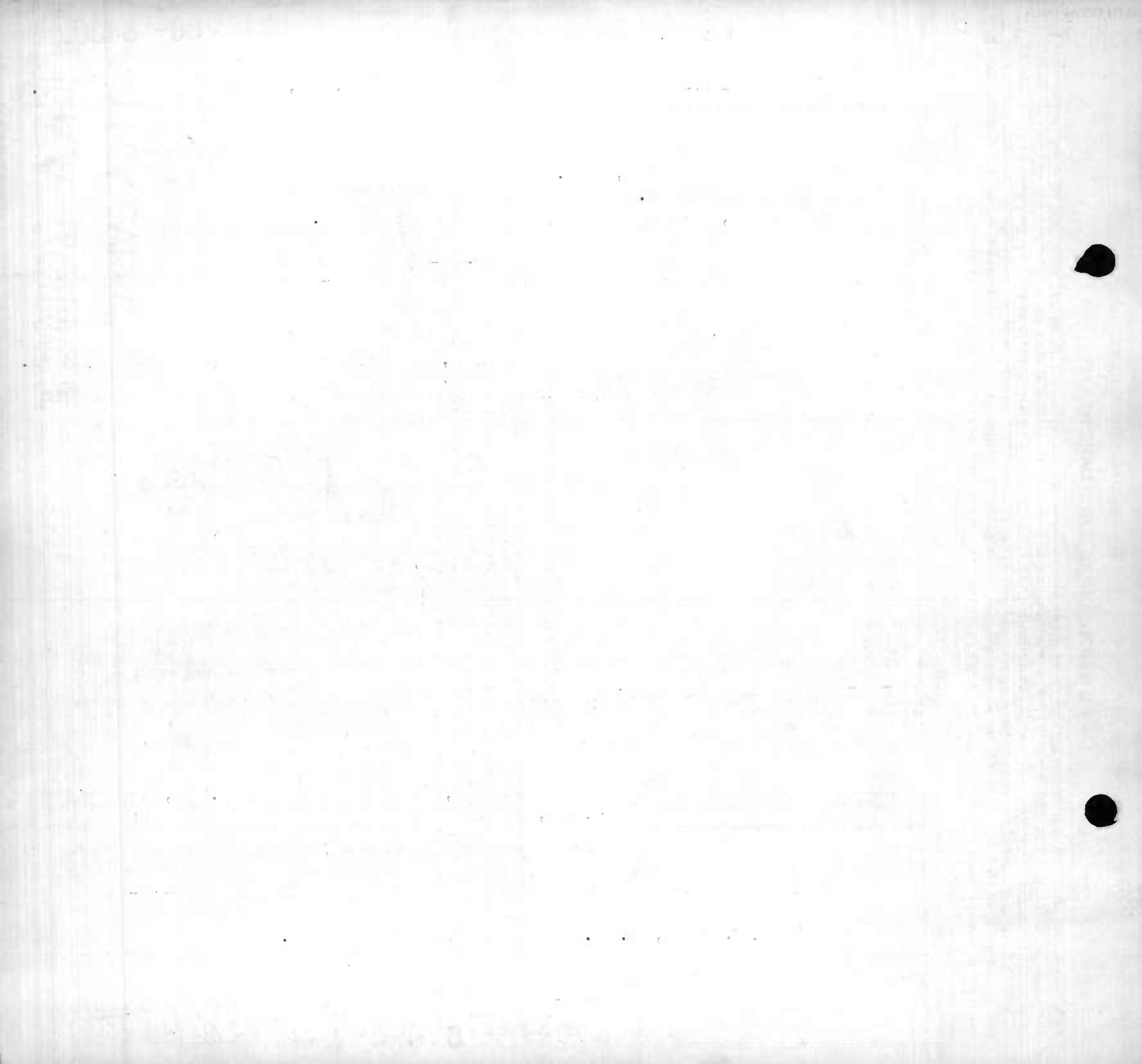
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-8430

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-8430

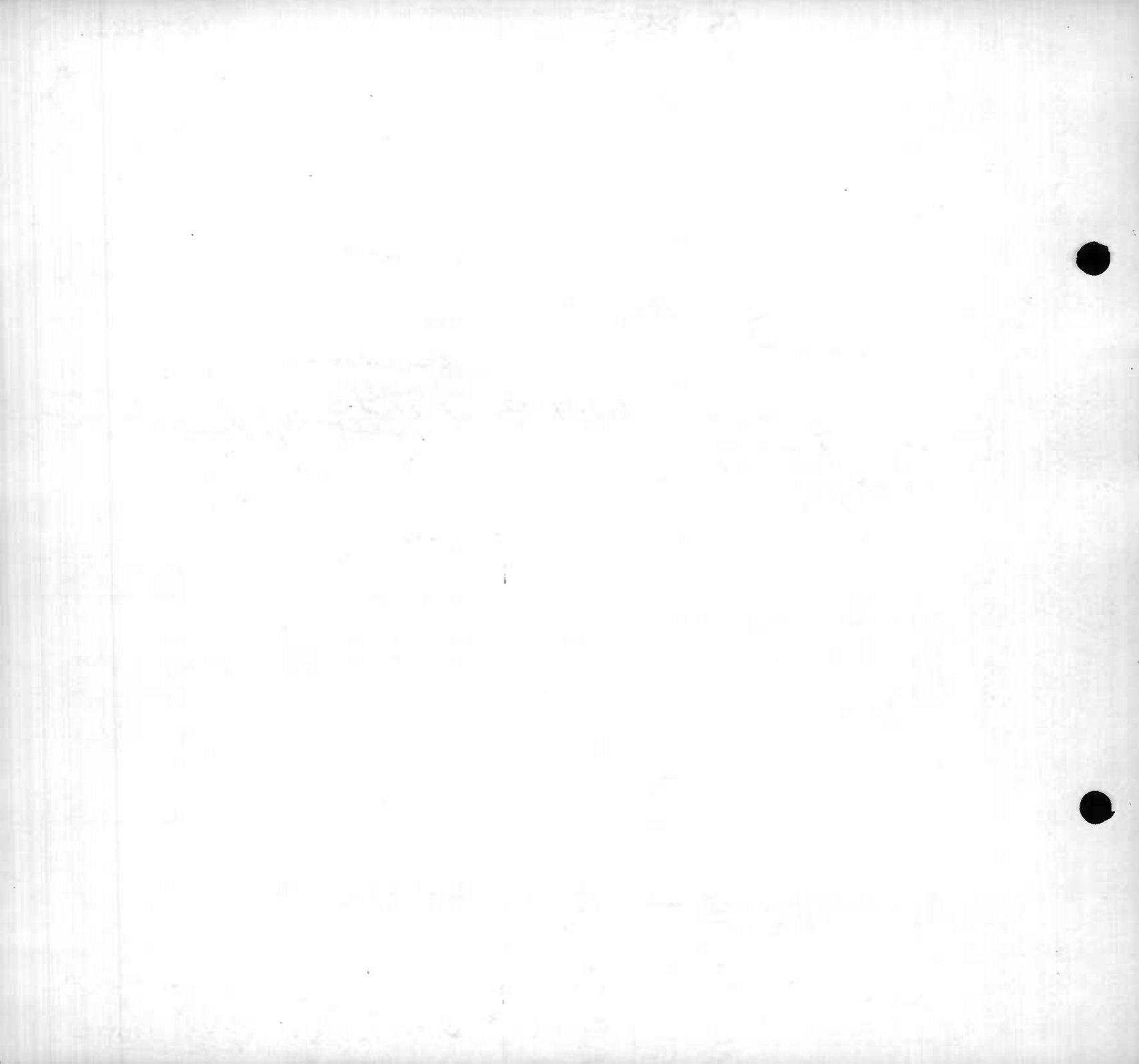
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Walter Blunt</b>		2. DATE AND HOUR OF DEATH <b>Aug. 11, 1968</b> <b>7:25 a.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>39 Provident Hospital, Inc. 1514 Division St. Baltimore, Maryland 21217</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY  C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>  E. STREET AND NUMBER <b>509 Wilson St.</b>			
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-10-27</b>	9. AGE (In years last birthday) <b>41</b>	If Under 1 Tr. Months: If Under 24 Hrs. Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Western Mill</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Robert Blunt</b>		14. MOTHER'S MAIDEN NAME <b>Ida Mrs. Mildred Edwards 1608 Division St.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>225-32-4469</b>		17. INFORMANT <b>Mrs Mildred Edwards 1608 Division St</b>	
18. <b>533.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Overwhelming infection and cerebral edema</b> <b>C. I. bleeding (peptic ulcer) post</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>operative and pancreatic fistula</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>540.0 II</b>					
19A. DATE OF OPERATION <b>3-7-15-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Peptic Ulcer</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>July 9, 1968</b> to <b>Aug. 11, 1968</b>		that (I) (we) last saw the deceased alive on <b>Aug. 11, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <b>Podina Chotikul M.D.</b>		23B. DATE SIGNED <b>8-12-68</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. Podina Chotikul</b>	
23D. ADDRESS <b>1514 Division St.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/16/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>M Auburn Cemetery</b>		24D. LOCATION (City, town, or county) <b>Baltimore Md</b>		(State)	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Saperstein</b>		25C. FUNERAL DIRECTOR <b>J. H. Halden</b> ADDRESS <b>1206 W. North Ave.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

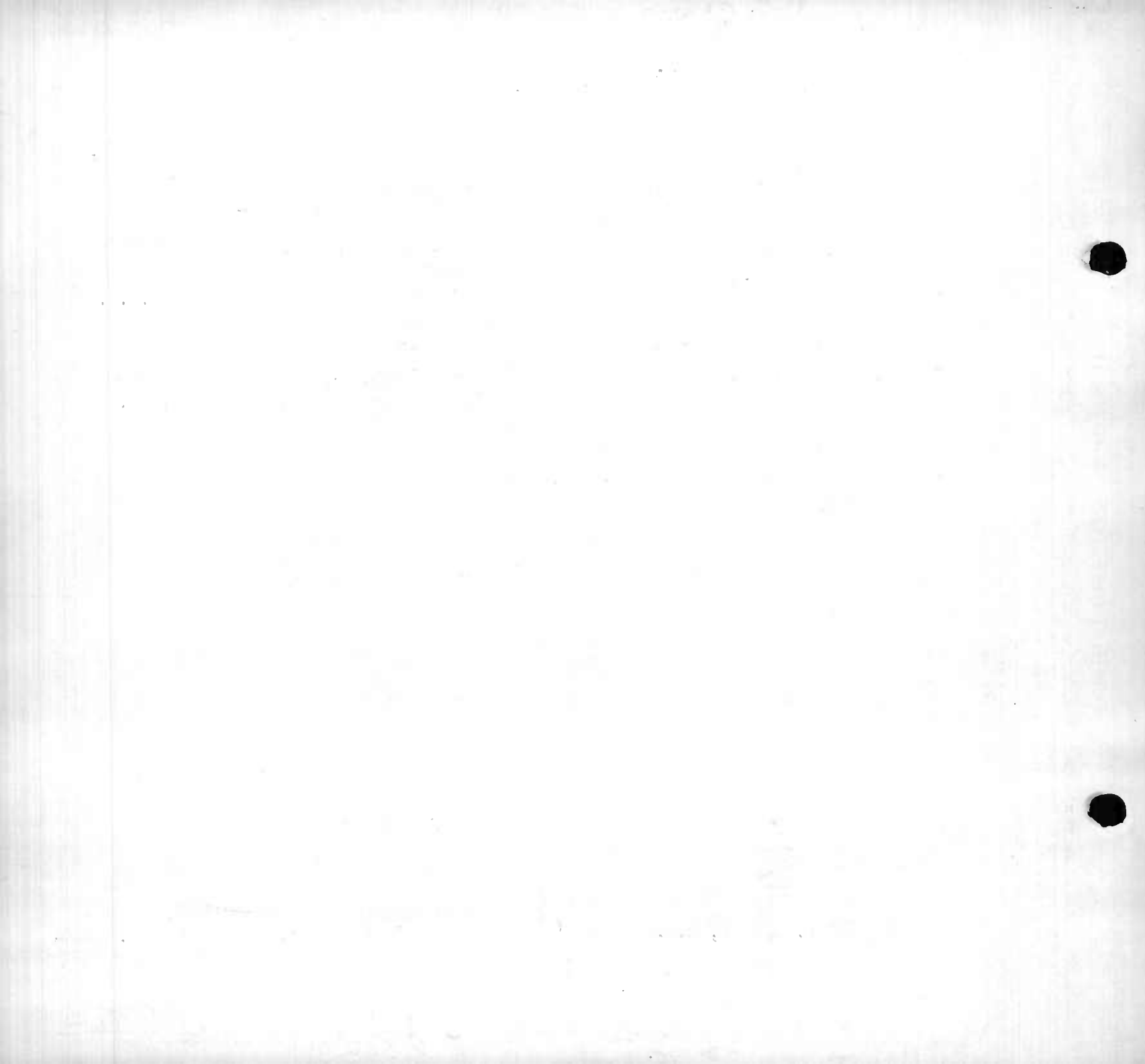
REG. NO. 68- 8431

VS 150-REV. 1/1/68



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. E-562				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-8432			
1. NAME OF DECEASED (Type or Print) <b>HERBERT H. EMERSON</b> <i>Herbert H. Emerson</i>				2. DATE AND HOUR OF DEATH <b>8/16/68</b> <b>8:00 A.M.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>31</b> <b>BALTIMORE CITY HOSPITALS</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>15-03</b>				C. CITY OR TOWN <b>BALTIMORE</b>			
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER <b>2502 PRESBURY STREET - 21216</b>			
5. SEX <b>MALE</b>		6. RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/5/12</b>		9. AGE (In years last birthday) <b>55</b>		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>OREN EMERSON</b>				14. MOTHER'S MAIDEN NAME <b>ADDIE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <b>RECORDS: Baltimore City Hospitals</b> <b>4940 Eastern Avenue, Baltimore, Md. 21224</b>			
18. <b>579.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>3-27.211</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac Arrest</b> (B) <b>Respiratory Failure</b> (C) <b>Chronic Obstructive Lung Disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>NO</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>8/15</b> 19 <b>68</b> to <b>8/16</b> 19 <b>68</b> , that (1) (we) last saw the deceased alive on <b>8/16</b> 19 <b>68</b> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				23A. SIGNATURE <i>Paul N. Kalkut, M.D.</i> <b>PAUL N. KALKUT, M.D.</b>				23B. DATE SIGNED <b>8/16/68</b>			
23C. PHYSICIAN'S NAME (Type or Print) <b>PAUL N. KALKUT, M.D.</b>				23D. ADDRESS <b>BALTIMORE CITY HOSPITALS</b> <b>4940 Eastern Avenue, Baltimore, Md. 21224</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>8/21/68</b>				24C. NAME OF CEMETERY OR CREMATORY <b>7th Avenue</b>			
24D. LOCATION <b>Baltimore Md</b>				25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>				25B. NAME OF REGISTRAR <i>Robert E. Stachura</i>			
25C. FUNERAL DIRECTOR <i>2302 W. North Avenue</i>				25D. ADDRESS <i>2302 W. North Avenue</i>							



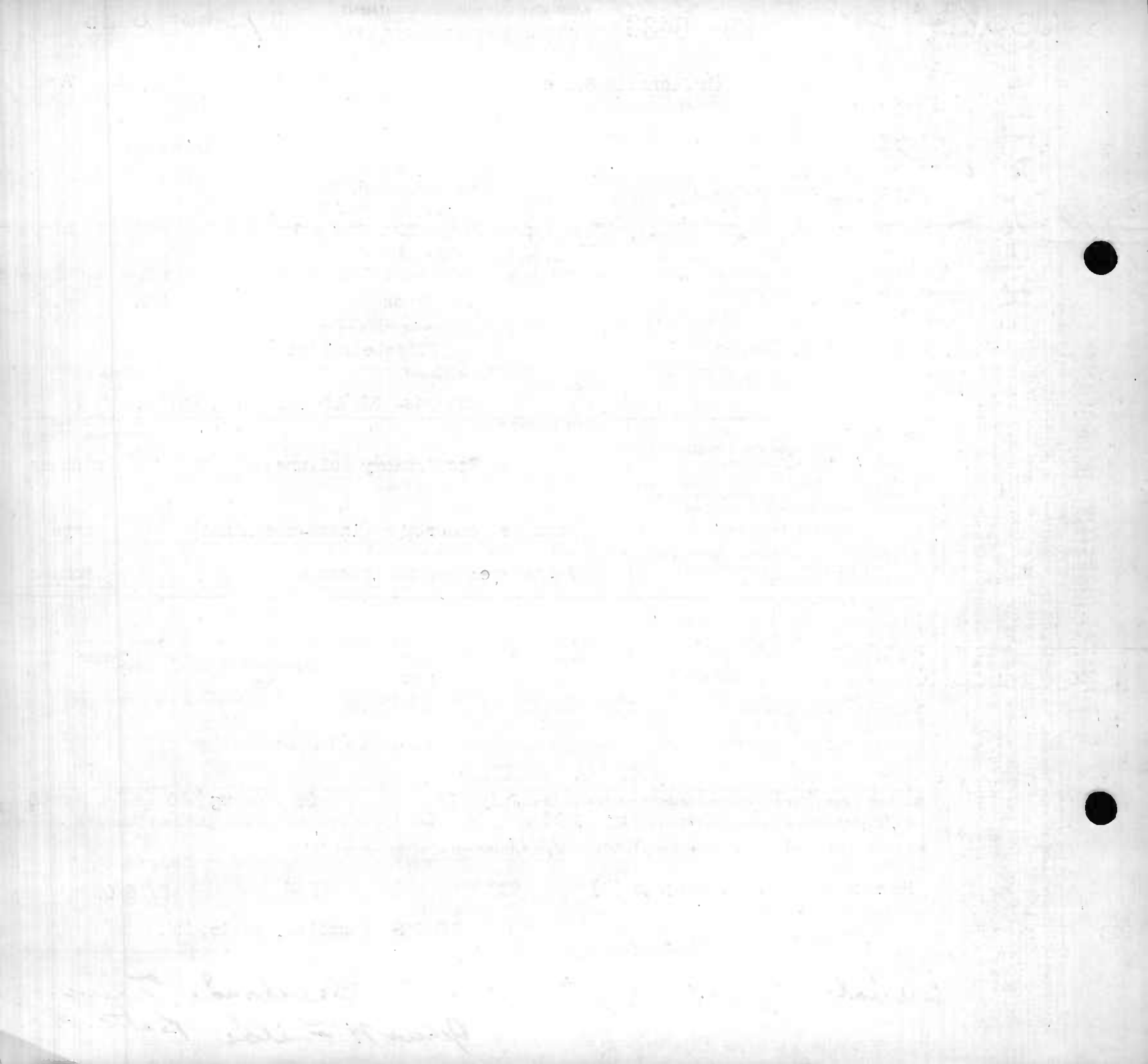
# 68- 8433 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 8433

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Eliza beth Jeanette Srite</b>		2. DATE AND HOUR OF DEATH <b>Aug. 16, 1968</b> <b>11</b> <b>A</b> <b>M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>US Public Health Service Hospital 3100 Wyman Park Drive</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Tenn.</b> B. COUNTY <b>V-39</b> C. CITY OR TOWN <b>Athens</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>Rt. 5 Box 566</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/19/03</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Texas</b>	
13. FATHER'S NAME <b>Hamilton R. Pierce</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Witt</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>	
18. <b>20501</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory failure</b> minutes ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Massive hemorrhage (intra-abdominal)</b> days (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Acute myelogenous leukemia</b> months (C) DUE TO, OR AS A CONSEQUENCE OF:					
19. <b>204311</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>yes</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>(Month) (Day) (Year) (Hour)</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 26</b> 19 <b>68</b> to <b>Aug. 16</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Aug. 16</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Norman H. Peckham, Surgeon (R)</b>				23B. DATE SIGNED <b>8/16/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Norman H. Peckham</b>		23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/13/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Sunset Memorial Gardens</b>	
24D. LOCATION (City, town, or county) (State) <b>Cleveland, Tenn.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR ADDRESS <b>James M. Fields, Balto. Md.</b>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-8434</u>	
BIRTH NO.		68-8434		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Foss, (FRANCIS) FRANK T.</u>		2. DATE AND HOUR OF DEATH <u>August 16, 1968 12<sup>10</sup> A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Church Home + Hospital</u> <u>35</u>		C. CITY OR TOWN <u>Wood Lawn</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>MALE</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>3/2/96</u>		9. AGE (In years lost birthday) <u>72</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Musician</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Leo Foss</u>			
14. MOTHER'S MAIDEN NAME <u>FRANCES BARHAMUS</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes 1918</u>			
16. SOCIAL SECURITY NO. <u>21803 0502</u>		17. INFORMANT <u>Stowey G. Foss -2801 Silver Hill Avenue Patient.</u>			
18. <u>152.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>MECHANICAL INTESINAL OBSTRUCTION</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 wks.</u>	
(B) <u>MEASTATIC CARCINOMA OF small bowel</u> DUE TO, OR AS A CONSEQUENCE OF: <u>2 mos.</u>		(C) _____		_____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>152.9 II</u>					
19A. DATE OF OPERATION <u>AUG. 13-1968</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>MECHANICAL OBSTRUCTION</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>8-11</u> 19 <u>68</u> to <u>8-16</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8-16</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Theodore A. Darwin M.D.</u>		23B. DATE SIGNED <u>8-16-68</u>		23C. PHYSICIAN'S NAME (Type) <u>THEODORE A. DARVIN M.D.</u>	
23D. ADDRESS <u>CHURCH HOME &amp; HOSPITAL 100 N. BROADWAY BALT., MD.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>8-19-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery - Baltimore, Md</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 18 1968</u>		25B. NAME OF REGISTRAR <u>John E. Galt</u>		25C. FUNERAL DIRECTOR <u>Ellsworth Armacost - 4600 Liberty Heights</u>	

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CHURCH STREET & HOSPITAL  
100 A. CANTONMENT - GALT

JOSEPH A. DARWIN M.D.  
JAMES A. DARWIN M.D.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

## 68- 8435 CERTIFICATE OF DEATH

REG. NO. 68- 8435

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Bracken; Mary M.</u>		2. DATE AND HOUR OF DEATH <u>8/15/68</u> <u>7<sup>25</sup></u> <u>P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital of Baltimore</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
			E. STREET AND NUMBER <u>5104 Palmer Ave</u> <u>21215</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/12/12</u>	9. AGE (In years lost birthday) <u>56</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD Carroll County</u>	
13. FATHER'S NAME <u>William Wheatley</u>			14. MOTHER'S MAIDEN NAME <u>Lee</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-16-5200</u>		17. INFORMANT <u>Thomas Bracken-5104 Palmer Avenue # 15</u>	
18. <u>410.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
			(B) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>20 years</u>
			(C) _____		
19. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>8/15</u> 19 <u>68</u> to <u>8/15</u> 19 <u>68</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>8/15</u> 19 <u>68</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Stanford H. Malinow MD</u>				23B. DATE SIGNED <u>8/15/68</u>	
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS <u>Sinai Hospital of Baltimore</u> <u>MD</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-19-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE RECEIVED BY HEALTH DEPT. <u>AUG 19 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Feltz</u>		25C. FUNERAL DIRECTOR <u>Ellsworth</u>	
				ADDRESS <u>4600 Liberty Hghts. Ave</u>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8436 BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68- 8436

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WILLIAM J. SMITH, Sr</b>		2. DATE AND HOUR OF DEATH <b>AUGUST 18, 1968 5:00 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland, D.S.A.</b> B. COUNTY <b>20-05</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>35 CHURCH HOME &amp; HOSPITAL</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>414 S. Smallwood St.</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-26-96</b>	9. AGE (In years last birthday) <b>71</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bkto. City</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Smith</b>		14. MOTHER'S MAIDEN NAME <b>Sophie Kisten</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES World War I</b>		16. SOCIAL SECURITY NO. <b>212-46-8647</b>		17. INFORMANT <b>Barbara Smith</b>	
18. <b>43619</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebro-vascular accident</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>331X II</b>		<b>Pneumonia</b>		<b>Pulmonary Infarct</b>	
19A. DATE OF OPERATION <b>1-12-68</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Pneumonia</b>	20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>July 20, 1968</b> to <b>August 16, 1968</b> , that (I) (we) last saw the deceased alive on <b>August 18, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Corazon Z. Vergara</b>		M.D. DEGREE <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>August 18, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>CORAZON Z. VERGARA</b>		M.D. DEGREE		23D. ADDRESS <b>Church Home &amp; Hosp., 100 N. Broadway</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8-21-68</b>	24C. NAME OF CEMETERY or CREMATORY <b>LONDON PARK</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	25C. FUNERAL DIRECTOR <b>GEORGE J. MULLER</b>		ADDRESS <b>2101 Frederick Ave.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 8437

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

GEORGE N. BARRY

2. DATE AND HOUR OF DEATH

8/16/68

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

34

BON SECOURS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MARYLAND

C. CITY OR TOWN

BALTIMORE

E. STREET AND NUMBER

3923 E. PRATT ST.

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

5. SEX

M

6. RACE

W

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

12/11/03

9. AGE (In years lost birthday)

64

If Under 1 Yr. Months

If Under 24 Hrs. Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired salesman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

JOHN BARRY

14. MOTHER'S MAIDEN NAME

GRAY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

212-20-3530

17. INFORMANT

Son, Geo. Barry, Jr.

ADDRESS

18. 197.8

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.

CAUSE OF DEATH

metastatic adenocarcinoma of liver

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF: progressive metastatic adenocarcinoma of liver

(B) metastatic adenocarcinoma of liver

DUE TO, OR AS A CONSEQUENCE OF: within liver

(C).....

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

13-6.2 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

18/8/68

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/4 19 68 to 8/16 19 68, that (I) (we) last saw the deceased alive on 8/16 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. MARK POOR

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

DEGREE

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/19/68

24C. NAME OF CEMETERY or CREMATORY

Holy Redeemer

24D. LOCATION

Balto Md

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 19 1968

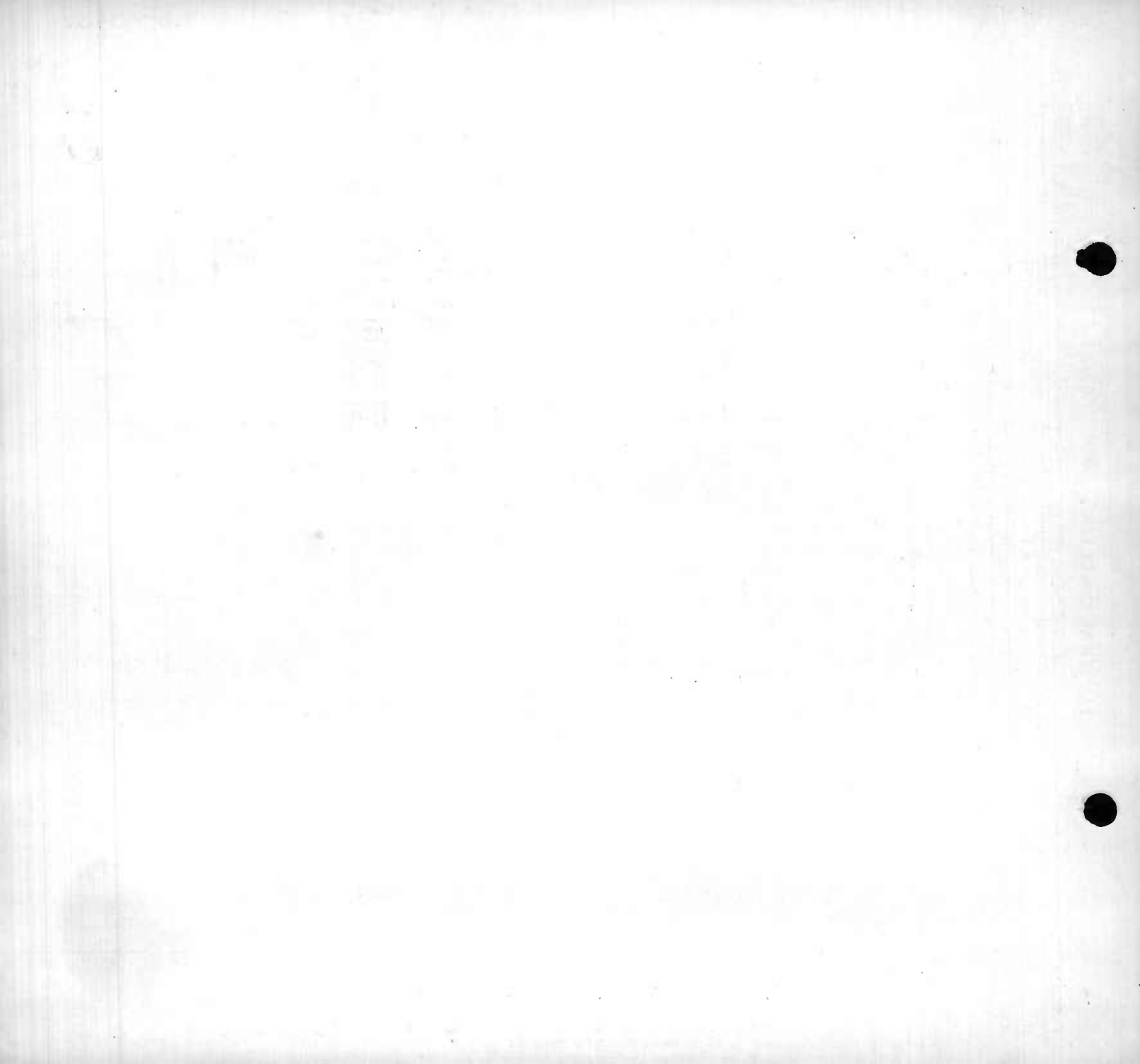
25B. NAME OF REGISTRAR

Dr. Mark Poor

25C. FUNERAL DIRECTOR

George J. Zannone 263 S. Loring

ADDRESS



P-320

68- 8438 BALTIMORE CITY HEALTH DEPARTMENT

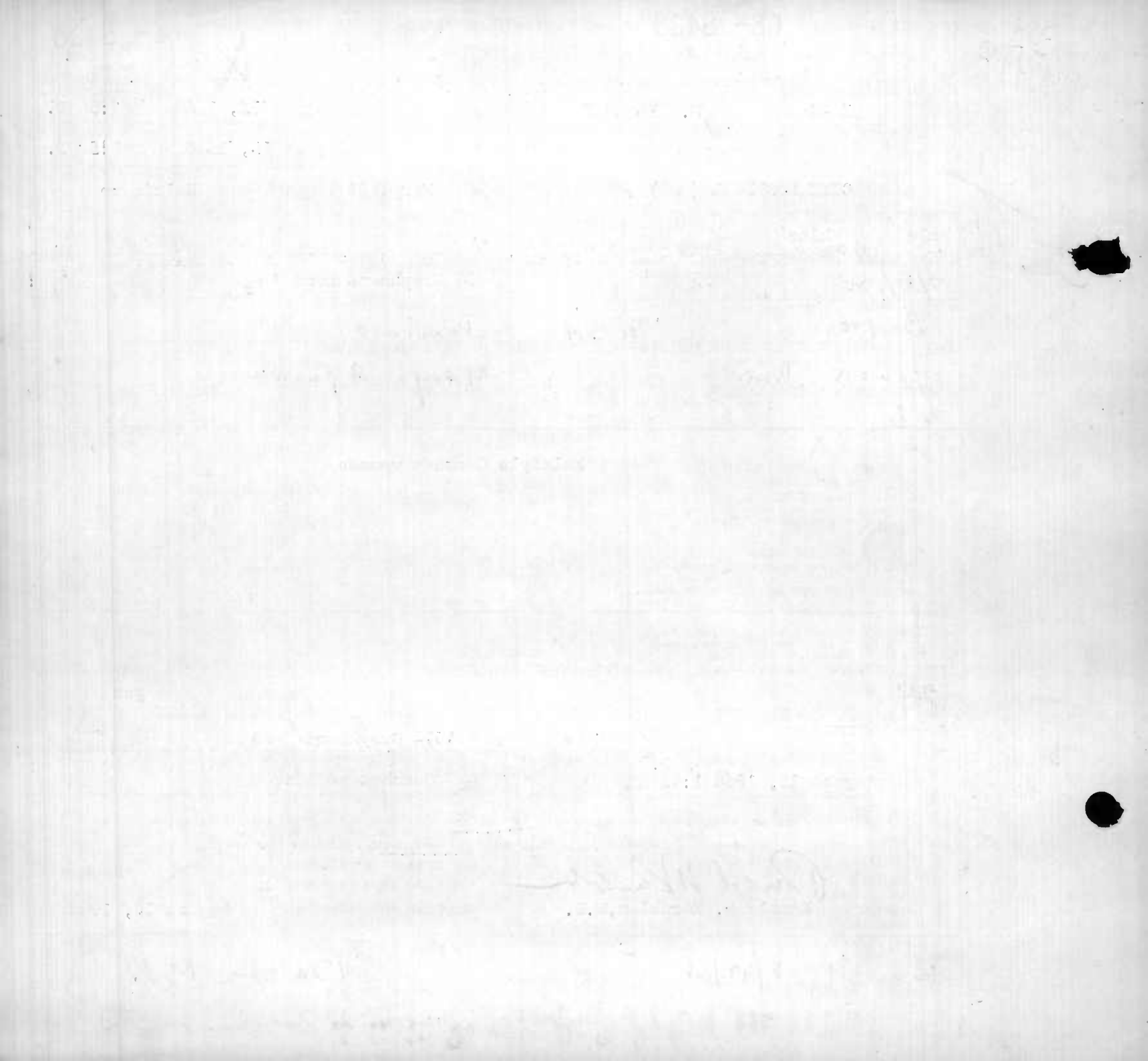
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 8438

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>VINCENT M. PATUCCI</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>August 15, 1968</b> Hour <b>2:50 P.</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>CITY HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>August 15, 1968</b> Hour <b>2:50 P.</b> M.	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Essex</b>	
9. DATE OF BIRTH <b>7/31/1913</b>		10. AGE (In years lost birthday) <b>55</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Balto.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trucks Driver</b>		15. MOTHER'S MAIDEN NAME <b>Mary Aquina</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Mary Aquina</b>		ADDRESS	
19. I <b>E 965 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Multiple Gunshot wounds</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>E 981 X</b>			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>674 Greyhound Road</b>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>August 15, 1968 1:45</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Gunshot wounds</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED <b>August 16, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/19/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Ronald N. Kornblum</b>	
25C. FUNERAL DIRECTOR <b>Joseph W. Zander</b>		ADDRESS <b>263 S. Loring St</b>	



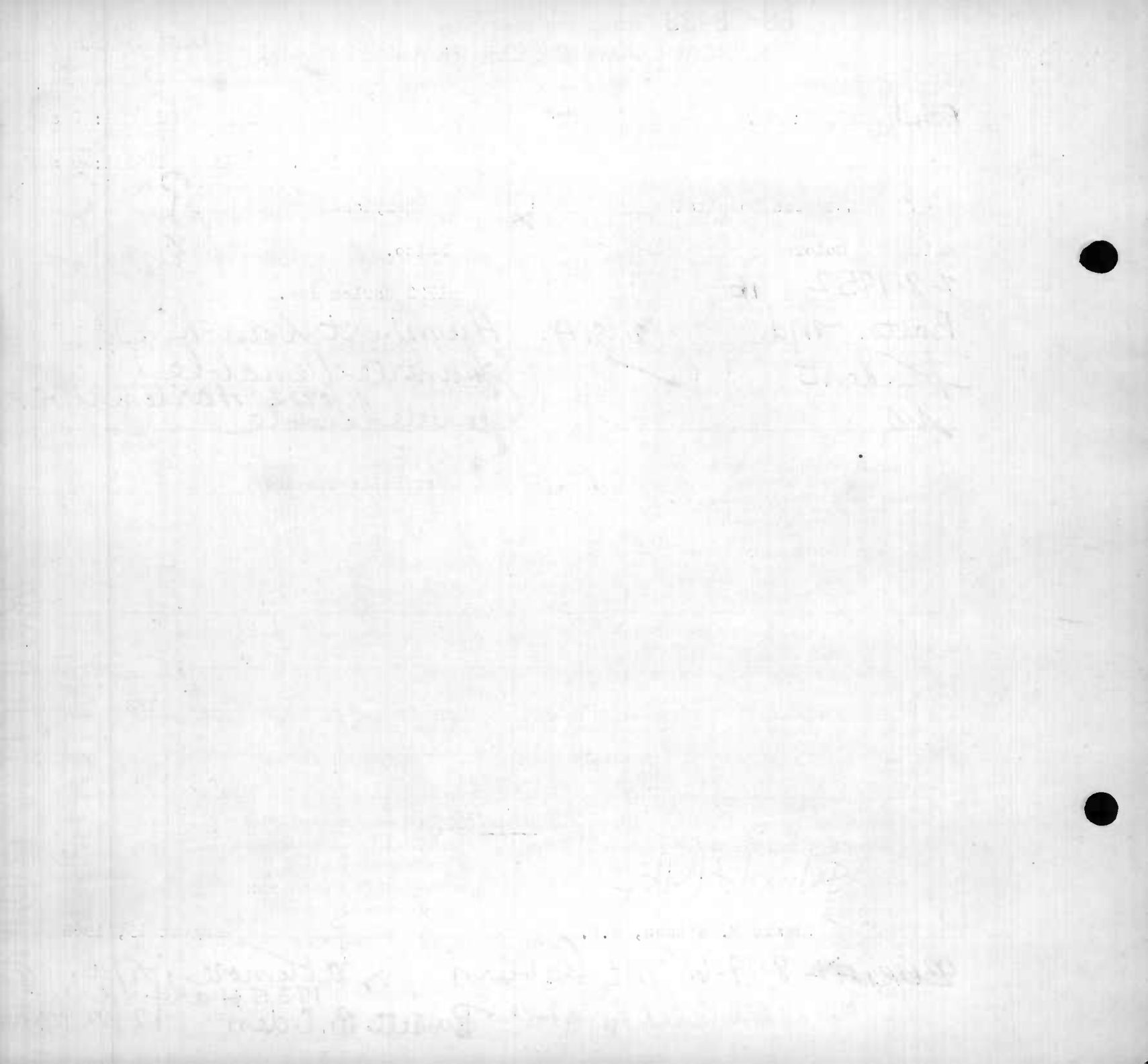
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 8439

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Ralph JAMES VENABLE</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>8 15 68 1:40 a.m.</b>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>46 Lutheran Hospital</b> ADDRESS OR LOCATION				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 15 1968 1:40 a.m.</b>			
6. SEX <b>Male</b>				7. RACE <b>Colored</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>7-8-1952</b>				10. AGE (In years lost birth day) <b>16</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Humbert Sawkins</b>			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				15. MOTHER'S MAIDEN NAME <b>Jeannette Venable</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				17. SOCIAL SECURITY NO. <b>1722 Harlem Ave.</b>		18. INFORMANT <b>Jeannette Venable</b>	
19. <b>3049</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Narcotics overdose</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Narcotics overdose</b>			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>323X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
20A. DATE OF OPERATION <b>2</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-19-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>Bernice B. Oden</b>		ADDRESS <b>1735 H. Alfred Ave. 21213</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
				ROBERT M. WISE SR.				16 AUG 1968 3:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD								4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)								A. STATE B. COUNTY			
MARYLAND GENERAL HOSP.								MD. BALTIMORE CITY			
C. CITY OR TOWN								D. INSIDE CITY LIMITS?			
BALTIMORE								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER								523 E. 23rd ST.			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
M		N		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8/29/07		60			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Cook				Restaurant				Tennessee			
13. FATHER'S NAME								14. MOTHER'S MAIDEN NAME			
WILLIAM WISE								VIRGINIA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
Yes				WWII				216-05-5401			
WIFE, ELIZABETH WISE, Same											
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH								CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)								PULMONARY EDEMA & CONGESTION			
ANTECEDENT CAUSES								(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.								ESOPHAGEAL VARICES, GI HEMORRHAGE			
(B) DUE TO, OR AS A CONSEQUENCE OF:								24 hrs			
(C) PORTAL CIRRHOSIS								years			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
16 Aug 68				UGI Bleeding				Yes.		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				(Month) (Day) (Year) (Hour)			
22. I certify that (X) (this hospital) attended the deceased from 15 AUG 1968 to 16 AUG 1968, that (X) (we) lost saw the deceased alive on 16 AUG 1968 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.											
23A. SIGNATURE								23B. DATE SIGNED			
HERRICK S. WARREN MD								16 Aug 68			
23C. PHYSICIAN'S NAME (Type)								23D. ADDRESS			
HERRICK S. WARREN								MARYLAND GENERAL HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME of CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)	
BURIAL				8/20/68		BALTO. NATIONAL CEM				5501 FREDERICK AVE BALTO. Maryland	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS			
AUG 19 1968				R. E. E. E. E.				Marshall W. Jones, Jr. 1735 Harford Ave			

Massachusetts General Hospital  
251 S. 2nd St.

8/20/08

M N

Tennessee

Eastman

Cooper

Virginia

Winthrop

251

251

Win

Win

10 And St UCI Building

10 And St

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10 And St

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-420		68- 8441		CERTIFICATE OF DEATH		REG. NO.		68- 8441	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>COLLIER POLLACK</b>				2. DATE AND HOUR OF DEATH <b>AUGUST 17, 1968 3<sup>40</sup> P.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Baltimore City Hospitals</b>						4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>501</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> E. STREET AND NUMBER <b>302 N. EDEN STREET 21231</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-22-07</b>	9. AGE (In years lost birthday) <b>61</b>	II Under 1 Yr. Months Days II Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>NEWBERN, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William Pollack</b>			14. MOTHER'S MAIDEN NAME <b>ANNIE MIDGETTE</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-01-4706</b>		17. INFORMANT <b>RECORDS: BCH:</b>		ADDRESS <b>4940 EASTERN AVE., BALTO., MD. 21224</b>			
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <b>Respiratory insufficiency</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Klebsiella Pneumonia</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Bronchogenic carcinoma</b> (C) <b>aortic incompetence</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day.</b> <b>1 wk.</b> <b>one year.</b> <b>10+ years</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>8-9-68</b> to <b>8/17</b> 19 <b>68</b> . that (I) (we) last saw the deceased alive on <b>8/17</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>David J. Shaw M.D.</b>				23B. DATE SIGNED <b>8/17/68</b>					
23C. PHYSICIAN'S NAME (Type) <b>DAVID J. SHAW M.D.</b>				23D. ADDRESS <b>4940 EASTERN AVE BALTO., MD. 21224</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-21-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cemetery A.A. Co Md</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO., MD.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Marshall W. Jones, JR.</b>		ADDRESS <b>1735 Harford Ave</b>			

Baltimore and Hospital

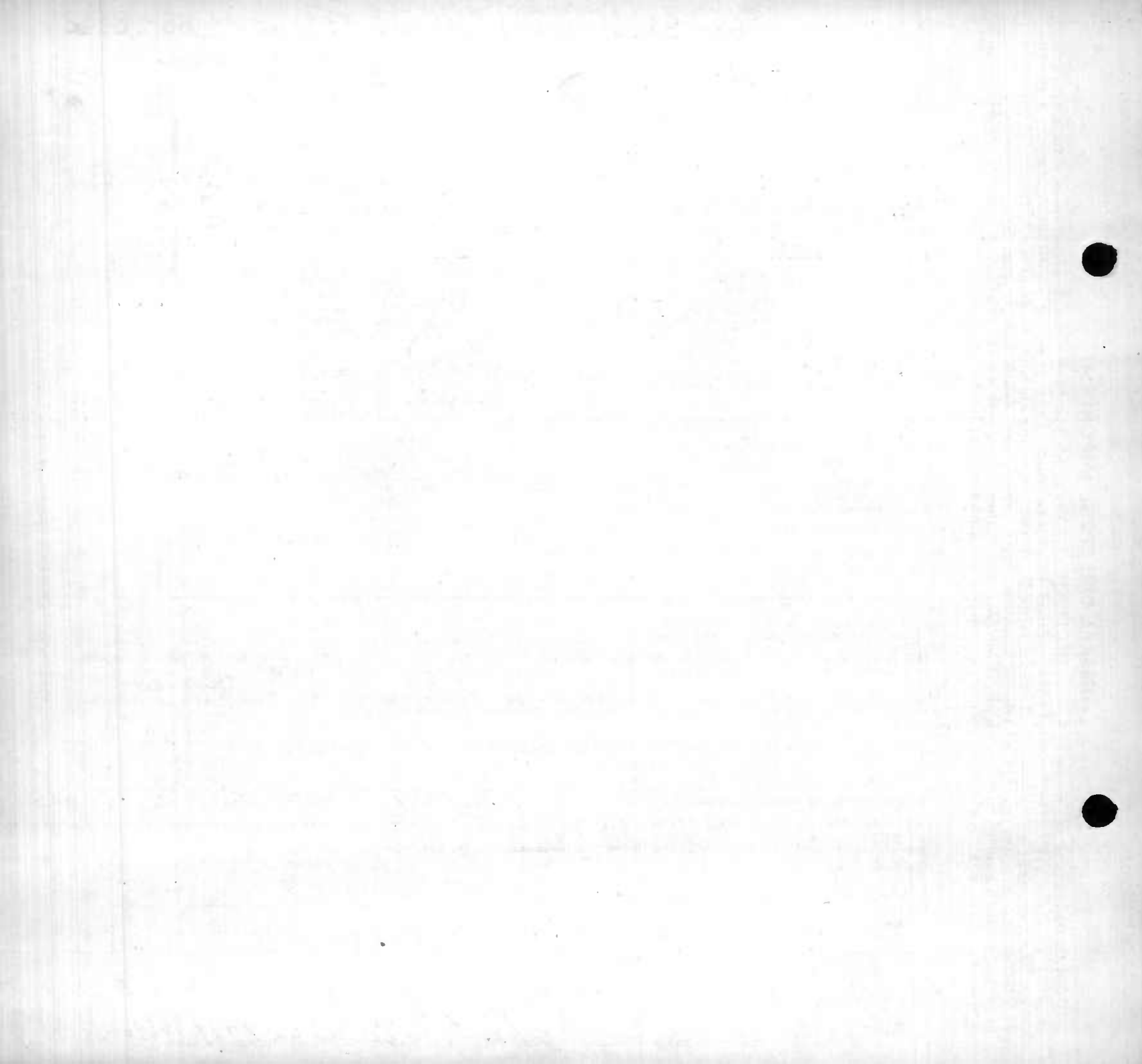
Geographical distribution  
Xiphosylla pueraria  
Bicentric dentate  
Cortic micromphala

David I Snow, M.D.  
Baltimore City Hospital

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-300		68- 8442		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 8442	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>SCOTT, Mary Ann</i>			
2. DATE AND HOUR OF DEATH <i>August 15, 1968 11<sup>20</sup> P.M.</i>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY				5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>BALTIMORE CITY HOSPITALS</i> <i>31 4940 EASTERN AVENUE</i> <i>BALTIMORE, MARYLAND # 21224</i>			
C. CITY OR TOWN <i>BALTIMORE</i>				D. INSIDE CITY LIMITS? <i>28-02</i> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <i>4200 MAINE AVENUE</i>				21207			
5. SEX <i>FEMALE</i>		6. RACE <i>NEGRO</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-1-82</i>	
9. AGE (In years lost birthday) <i>86</i>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>				10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <i>VIRGINIA</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Moore</i>				14. MOTHER'S MAIDEN NAME <i>Hester Bell</i>			
15. Was Deceased ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i></i>			
17. INFORMANT <i>BALTIMORE CITY HOSPITALS</i> ADDRESS <i>REC ORDS: 4940 EASTERN AVENUE</i> <i>BALTIMORE 6, MARYLAND #21224</i>							
18. <i>458.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Intra-abdominal Hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i></i>			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hr</i>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>467.2 II</i>							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>August 7</i> 19 <i>68</i> to <i>August 15</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>August 15</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Wm Mac Donald</i>				23B. DATE SIGNED <i>8/15/68</i>		23C. PHYSICIAN'S NAME (Type) <i>WILLIAM MAC DONALD M.D.</i>	
23D. ADDRESS <i>BALTIMORE CITY HOSPITALS</i> <i>4940 EASTERN AVENUE</i>				23E. ADDRESS <i>21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>8/20/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Antietam Memorial Park, Ann. Balt., Md</i>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 19 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Fathman</i>		25C. FUNERAL DIRECTOR <i>Robert Williams</i>		25D. ADDRESS <i>1701 N Bond St.</i>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8443

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MACK M. DUBOSE

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐Month  
Day  
YearDay  
Year  
HourYear  
Hour

Hour

4:00p m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Franklin Square Hospital

3. DATE  
PRONOUNCED DEAD

August

14

1968

4:00 pm.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

Colored

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

Sept. 8, 1908

10. AGE (In years  
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1103 Cloney St.

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Perstell Dubose

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Longshoreman

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Louise Martin

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

705-10-6313

18. INFORMANT

Mrs. Eddie Dubose

ADDRESS

1103 Cloney St.

19.

412.4 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.422.1 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME  
OF INJURY  
(APPROX.)22E. INJURY OCCURRED  
WHILE AT  
WORK ☐ NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 15, 1968

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

Aug 17, 1968

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cemetery

24D. LOCATION (City, town or county)

Westport (Baltimore) Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 19 1968

25B. NAME OF REGISTRAR

Joseph E. Jones

25C. FUNERAL DIRECTOR

Joseph E. Jones

ADDRESS

2222 W. North Ave  
Baltimore, Md.

312-83

312-83

100

100

100

100

100

100

100

WALKER

WALKER

WALKER

WALKER

WALKER

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO. 68-13820

1. NAME OF DECEASED (Type or Print) <b>TAMMY SAUNDERS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>8 14 68 7:15 a.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 321 S. Franklinton Rd. D.O.A.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 14 1968 7:15 a.m.</b>	
6. SEX <b>Female</b>		7. RACE <b>Colored</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>July 19, 1968</b>		10. AGE (In years lost birthday) <b>3 1/2 wks.</b>	
11. BIRTH PLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Wendell Saunders</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>20-04</b>	
15. MOTHER'S MAIDEN NAME <b>Beane E. Moore</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown. If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Mr. Wendell Saunders</b> ADDRESS <b>2516 W. Baltimore St.</b>	
19. <b>485 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Branchopneumonia</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Sudden death in infancy</b> DUE TO, OR AS A CONSEQUENCE OF: <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. DATE OF OPERATION	
21. AUTOPSY? (Yes or No) <b>YES</b>		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Edward F. Wilson, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>August 14, 1968</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>August 14, 1968</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug 17, 1968</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Westport (Baltimore) Md</b>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Joseph H. Hiss</b>	
25C. FUNERAL DIRECTOR <b>2222 W. North</b>		25D. ADDRESS	

1875-76

Mr. J. H. Jones  
Care of J. H. Jones  
The Methodist Church, Boston, Mass.

Sept. 18, 1875  
Boston, Mass.  
Dearest

WALTER B. JONES

Dear Mr. Jones, I have just received your letter of the 14th inst. and am glad to hear from you. I am well and hope this finds you the same.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-8445</u>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>PORTER T. BOND</u>		2. DATE AND HOUR OF DEATH <u>8-17-68 12:20 PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>4-01</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 Lutheran Hospital A Maryland</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>208 E Lexington Street</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/9/1892</u>	9. AGE (In years lost birthday) <u>76</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ARCHITECT</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>R. J. CARROLL &amp; Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>WILLIAM BOND</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>216-32-5194</u>		
			17. INFORMANT <u>MISS CONSTANCE E. BOND</u>		
			ADDRESS <u>6120 PARKWAY DRIVE</u>		
18. <u>781.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardio Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>Palatal paralysis &amp; Cardio Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		
19. <u>781.4 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7-16-1968</u> to <u>8-17-1968</u> , that (I) (we) last saw the deceased alive on <u>8-17-68</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. Baig (BAIG.)</u>				23B. DATE SIGNED <u>8-17-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Sborofsky</u>				23D. ADDRESS <u>7929 Stevenson Rd 21208</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/21/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Oaklawn</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto. Co., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 19 1968</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co.</u>			
25D. ADDRESS <u>4905 York Rd. Balto. 12, Md.</u>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

## 68- 8446 CERTIFICATE OF DEATH

REG. NO. 68- 8446

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

RESSIE BUTLER

2. DATE AND HOUR OF DEATH

8/14/68

4 52 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

SOUTH BALTIMORE GENERAL HOSPITAL  
HANOVER ST.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

4100 RITCHIE HIGHWAY

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

4100 RITCHIE HIGHWAY

5. SEX

FEMALE

6. RACE

CAU

7. MARRIED

☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

5-23-05

9. AGE (In years last birthday)

63

If Under 1 Yr. Months: Days: Hours: Min.

If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

DELAWARE

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

PATRICK O'NEILL

14. MOTHER'S MAIDEN NAME

MARY JANE MARKER

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

212-09-0369

17. INFORMANT

BERNARD E. BUTLER 4100 RITCHIE HWY

ADDRESS

18.

519.2 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

ARRHYTHMIA (CARDIAC)

MINUTES

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)

COR PULMONALE

YEARS

DUE TO, OR AS A CONSEQUENCE OF:

(C) CHRONIC OBSTRUCTIVE AIRWAY DISEASE

YEARS

MEDICAL CERTIFICATION

527.2 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/29/1968 to 8/14/1968, that (I) (we) last saw the deceased alive on 8/14/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

John G. Frizzera M.D.

DEGREE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

8/14/68

23C. PHYSICIAN'S NAME (Type)

JOHN G. FRIZZERA M.D.

DEGREE

23D. ADDRESS

1701 INGRAM RD BALTIMORE MD.

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

8/17/68

24C. NAME OF CEMETERY OR CREMATORY

GLENHAVEN MEM. PK.

24D. LOCATION

(City, town, or county)

GLENBURNIE, MD.

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 19 1968

25B. NAME OF REGISTRAR

Robert E. Frizzera

25C. FUNERAL DIRECTOR

8/14/68 DENNY, INC. 715 LIGHT ST.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

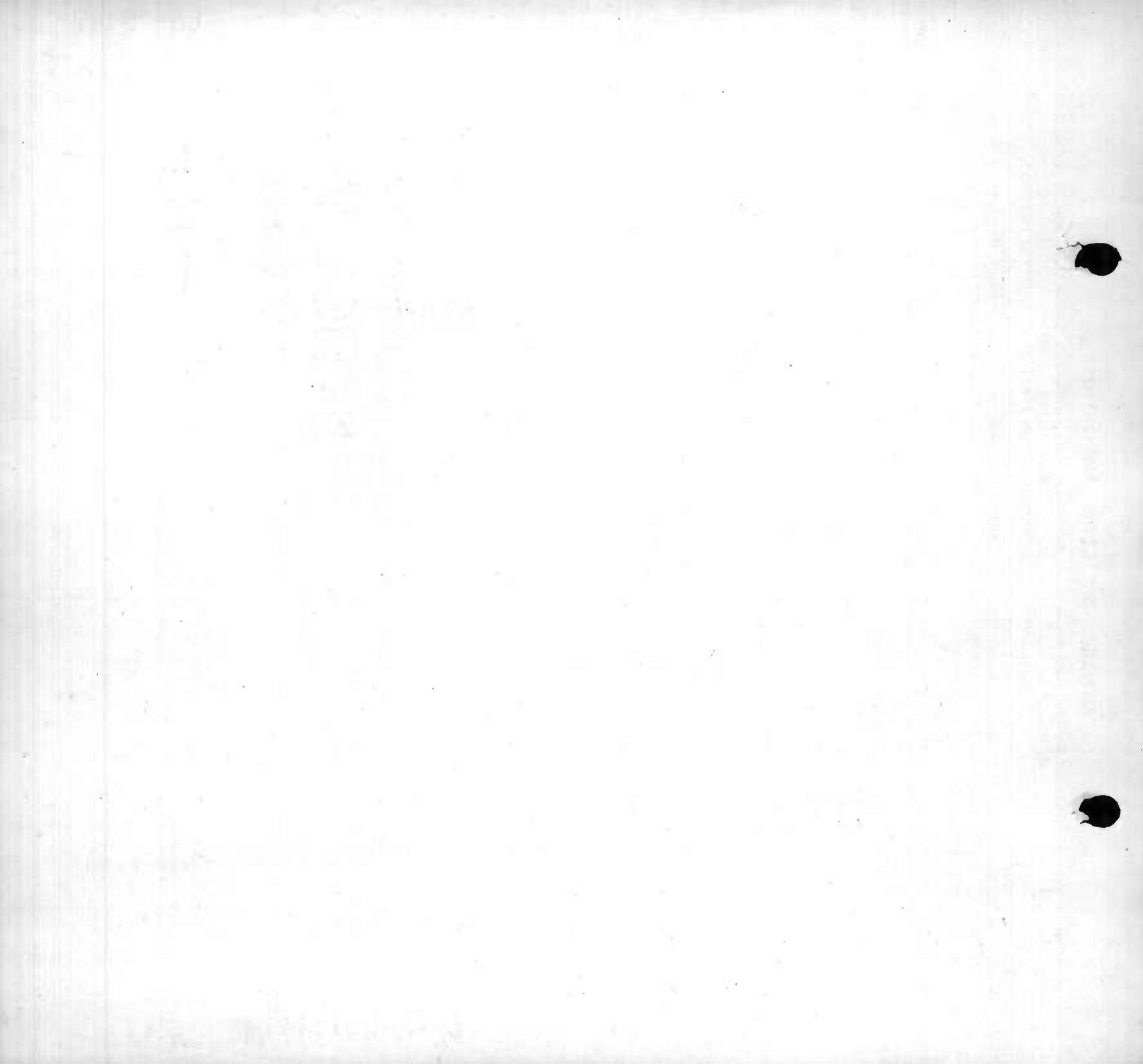
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 8447. CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68- 8447

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JACKSON, Bessie H.</b>		2. DATE AND HOUR OF DEATH <b>8/15/68 1:30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BON SECOURS HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <b>MARYLAND</b>	
		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>602 N. PAYSON</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-9-24</b>	9. AGE (In years last birthday) <b>44</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>HOWARD Huey</b>		14. MOTHER'S MAIDEN NAME <b>SALLY Huey</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Ernest Jackson</b>	
				ADDRESS <b>Same</b>	
18. <b>582x I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CONGESTIVE heart failure</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertension</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>Chronic renal disease</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Chronic renal disease</b>		(C)	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>592x II</b>					
19A. DATE OF OPERATION <b>8-14-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-1-68</b> to <b>8-15-68</b> , that (I) (we) last saw the deceased alive on <b>8-14-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Benito Martinez M.D.</b>		DEGREE		23B. DATE SIGNED <b>8-15-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Benito MARTINEZ</b>		DEGREE		23D. ADDRESS <b>BON SECOURS HOSPITAL</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-20-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Philip G. Turner</b>		25C. FUNERAL DIRECTOR <b>Phillips Funeral Home</b>	
				ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8448 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 8448

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

EMORY COLE

2. DATE AND HOUR OF DEATH

7:45PM 8-16-68

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

MD.

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1137 MYRTLE AVE, 21201

5. SEX

M

6. RACE

N

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

NEGRO

MALE

8. DATE OF BIRTH

9-3-93

9. AGE (In years - last birthday)

72

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED POSTAL CLERK

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

UNITED STATES

13. FATHER'S NAME

JACOB COLE

14. MOTHER'S MAIDEN NAME

MARY JANE RYAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWI

16. SOCIAL SECURITY NO.

220 36 5387

17. INFORMANT

Selma Cole

ADDRESS

Same

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Renal Failure

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Amuloidosis & Hypotension

(C)

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

One month  
July 15, 1968

At least two months

MEDICAL CERTIFICATION

289.1 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A):

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from July 15, 1968 to Aug 16, 1968, that (1) (we) lost saw the deceased alive on Aug 16, 1968 and that in my (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Douglas T. Fearon M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

Aug 16, 1968

23C. PHYSICIAN NAME (Type)

DOUGLAS T. FEARON M.D.

23D. ADDRESS

The Johns Hopkins Hosp. Baltimore Md.

24A. BURIAL CREMATION REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 19 1968

25B. NAME OF REGISTRAR

Robert E. Phillips

25C. FUNERAL DIRECTOR

Robert E. Phillips 1727 N. Mount St.

ADDRESS

Handwritten text, possibly a signature or name.

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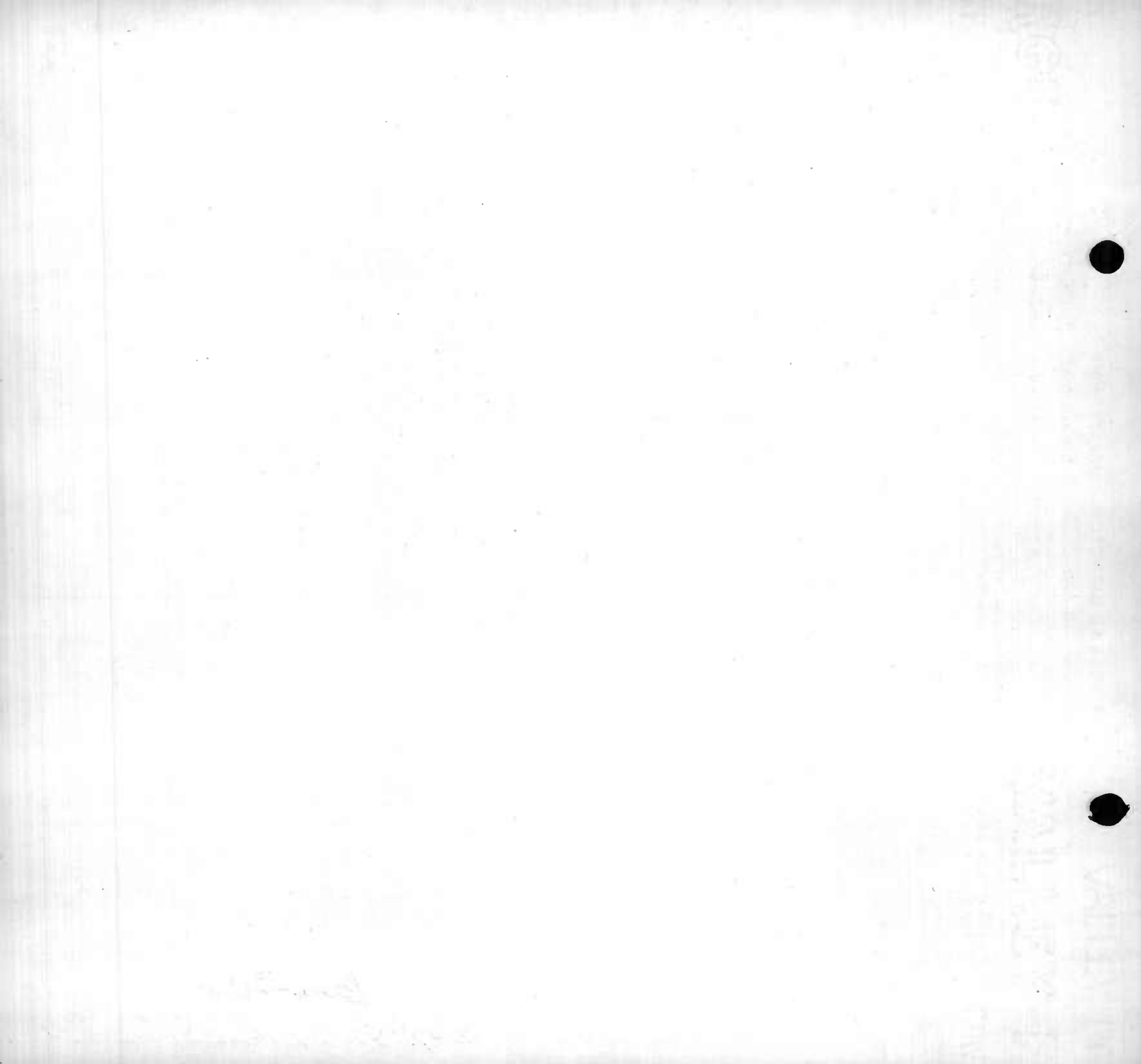
**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8449 **CERTIFICATE OF DEATH**

REG. NO. 68- 8449

BIRTH NO.		1. NAME OF DECEASED (Type in full) <b>HEIGHT FRAZIER RUTH R.</b>		2. DATE AND HOUR OF DEATH <b>August 14, '68 5:35 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>46 Lutheran Hospital of Maryland</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
ADDRESS OR LOCATION			E. STREET AND NUMBER <b>1229 Poplar Grove Street</b>		
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-6-1905</b>	9. AGE (In years lost birthday) <b>63</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Bethel North Carolina U.S.A.</b>	
13. FATHER'S NAME <b>Alexander Height</b>			14. MOTHER'S MAIDEN NAME <b>MaKinda Walker</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>578-20-7467</b>		17. INFORMANT <b>From chart</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac arrest.</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Myocardia infarct.</b> DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>420.1 II</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-5-1968</b> to <b>8-14-1968</b> , that (I) (we) lost saw the deceased alive on <b>8-14-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>C.S. Ming</b>				23B. DATE SIGNED <b>8-14-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>CHEE SHWE MING</b>				23D. ADDRESS <b>Lutheran Hospital of Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-19-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Carver Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Laurel, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jones</b>	
25C. FUNERAL DIRECTOR <b>Phillips</b>		25D. ADDRESS <b>1725 W. Federal Home Insurance St.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 8450 CERTIFICATE OF DEATH

BIRTH NO. 68-14835

1. NAME OF DECEASED  
(Type or Print)

Mary Lee Lucas

2. DATE AND HOUR OF DEATH

Aug. 12, 1968 | 7:30 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Tennessee

C. CITY OR TOWN

Kingsport

E. STREET AND NUMBER

1744 Jared Drive

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Aug. 11, 1968 24hrs

9. AGE (In years last birthday)

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

1

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Joe Lucas

14. MOTHER'S MAIDEN NAME

Frances Harvey

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

—

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS

Hospital records

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Heart Failure-Cardiac Arrest 24 hrs  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

773.0 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Aug. 12 12 noon 68 to Aug. 12 7:30pm 1968, that (I) (we) last saw the deceased alive on Aug. 12 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

David Waller MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

Aug. 13, 1968

23C. PHYSICIAN'S NAME (Type)

David A. Waller, M.D.

23D. ADDRESS

The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/14/68

24C. NAME of CEMETERY or CREMATORY

Bel Air Memorial Gardens

24D. LOCATION

Belair, Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 12 1968

25B. NAME OF REGISTRAR

John A. Morgan, Inc.

25C. FUNERAL DIRECTOR

John A. Morgan, Inc. 3000 E. Baltimore St.

ADDRESS

WILLIAM W. BROWN

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>68-8451</b>	
BIRTH NO.		<b>68-8451</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Charles K. Eagers</b>		2. DATE AND HOUR OF DEATH <b>8-15-68 13:15 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 Union Memorial Hospital</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>9-06</b> D. STREET ADDRESS (If rural, give location) <b>1606 E. 30th St.</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>11/17/10</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>7</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Henry G. Eagers</b>		14. MOTHER'S MAIDEN NAME <b>Mary Kennedy</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>Mrs. Mary Eagers 4503 Underwood Rd.</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarction</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19. <b>420.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7-24 1968</b> to <b>8-15 1968</b> , that (I) (we) last saw the deceased alive on <b>8-15 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Stephen Goldberg</b>				23B. DATE SIGNED <b>8-15-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>STEPHEN GOLDBERGER,</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/17/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>John A. Moran, Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>3000 E. Baltimore St.</b>	

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Myocardi infarction

21-8 00

5-31 00

8-12

8-12-00

John Doe

1000 3 001

1000 3 001

# FUNERAL DIRECTOR: IMPORTANT

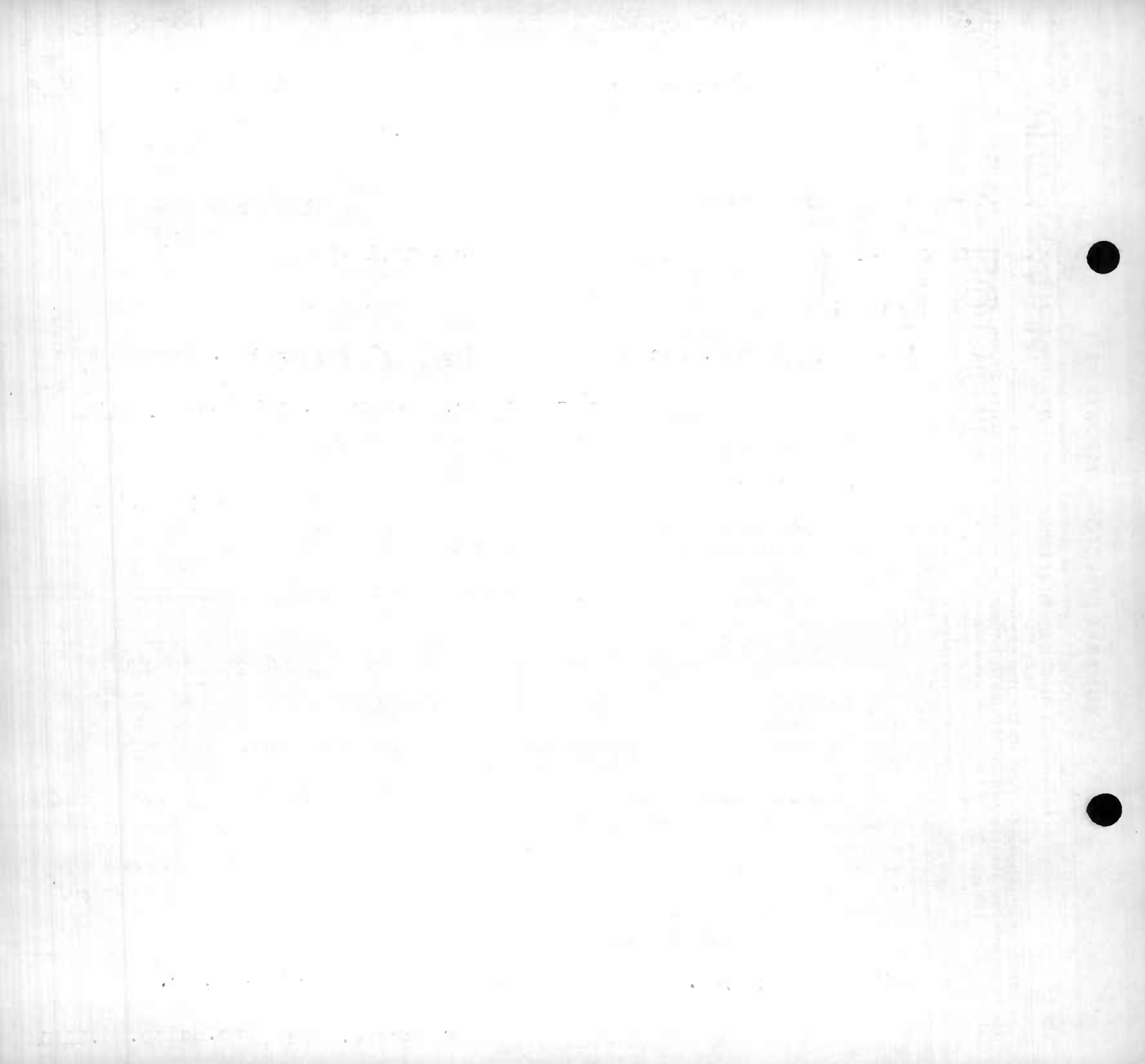
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8452

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 8452

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Marie Ruth Schmidt		August 15, 1968. 4 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Md.	
00 3154 Ravenwood Avenue				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3154 Ravenwood Avenue	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	April 18, 1895		73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John F. Pickel			Eva B. Bartholomae		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		217-18-6381-D		2022 Old Fred. Rd. 21228	
18. 412.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Arteriosclerotic Hypertensive Cardio-vascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 26 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 443X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from 8-5-1942 to 6-24-1968, that (I) ( <del>was</del> ) last saw the deceased alive on 6-24-1968 and that in (my) ( <del>your</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE Milton C. Lang, M.D.				23B. DATE SIGNED 8-17-68	
23C. PHYSICIAN'S NAME (Type) MILTON C. LANG, M.D. 2117 BELAIR ROAD BALTIMORE, MD. 21213				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		8/19/68.		Western Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 19 1968		Leonard J. Ruck, Inc.		Balto. Md. 21214	



Not a medical examiner case per Dr. Fultz. S. Tolomeo  
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8453 CERTIFICATE OF DEATH

REG. NO. 68- 8453

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>McDonough Patrick J Sr</b>		2. DATE AND HOUR OF DEATH <b>8/17/68 9<sup>38</sup> 4 M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>44 Union Memorial Hospital</b>		4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-01</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Fireman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. City</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>William McDonough</b>		14. MOTHER'S MAIDEN NAME <b>Mary O'Malley</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-28-0355</b>		17. INFORMANT <b>Patrick J McDonough Jr</b>	
18. <b>441.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Blood loss - Cardiovascular failure.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Rupture of Abdominal aortic aneurysm</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Blood loss - Cardiovascular failure.</b> (B) <b>Abdominal aortic aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>8/17/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Rupture abdominal aortic aneurysm</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/17/68 4 a.m.</b> to <b>8/17/68 10 a.m.</b> that (I) (we) last saw the deceased alive on <b>8/17/68 9.38 a.m.</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>S. M. Tolomeo M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>8/17/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>S. M. TOLOME M.D.</b>		23D. ADDRESS <b>UNION MEMORIAL HOSP. BALTIMORE, MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/20/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>Aug 19 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fink</b>		25C. FUNERAL DIRECTOR <b>Donald J. Ruck Inc</b>			
ADDRESS <b>Balto. Md</b>					

2/26/28

Wm O. Hall

Historical and  
Literary

8/17/28

2/26/28

Wm O. Hall

Wm O. Hall

Wm O. Hall

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 68- 8454 CERTIFICATE OF DEATH

REG. NO.

68- 8454

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Anna Mary Mazzulli		August 18, 1968. 5 <sup>00</sup> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
00 2122 St. Paul Street				Md. 9-06	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Owner		Grocery Store		Jan. 16, 1907. 61	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		9. AGE (In years last birthday)	
Virginia		USA		61	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Nicholas Failla				Rose Camaratta	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		Mr. Louis Mazzulli, 6627 Wycombe Way, Balto. 21234	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
174X I		Carcinoma of R Breast - metastasis to brain.			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
170X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from June 19 68 to 8/18 19 68, that (I) (we) last saw the deceased alive on 8/17 1968 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Joseph R. Liberto, M.D.				8/19/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Joseph R. Liberto				3508 Bank Street	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/21/68		Holy Redeemer Cemetery	
25A. DATE REC'D FOR HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
Aug 19 1968		Leonard J. Ruck, Inc. Balto. Md. 21214			

2. *Antennaria dioica* (L.) Link.  
var. *racemosa* (L.) Link.

John R. Allen, M.D.  
2/10/03  
2/10/03  
2/10/03

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8455		Baltimore City Health Department		REG. NO. 68- 8455	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <b>PETER J. DOERFLER, Sr.</b>		2. DATE AND HOUR OF DEATH <b>AUGUST 17, 1968 4:30 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>35 CHURCH HOME &amp; HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>USA</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2615 Gibson Avenue</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 28, 1894</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>H.S. Crocker Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Franz Doerfler</b>			14. MOTHER'S MAIDEN NAME <b>Anna Zehner</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>215-05-4181</b>		17. INFORMANT <b>Mrs. Hilda E. Doerfler</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>420.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Chronic Obstructive Pulm. Disease</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute MI ?</b> (B) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>August 16</b> 19 <b>68</b> to <b>August 17</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>August 17</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Corazon Z. Vergara, M.D.</b>				23B. DATE SIGNED <b>Aug. 17, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>CORAZON Z. VERGARA, M.D.</b>				23D. ADDRESS <b>Church Home Hosp., 100 N. Broadway</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/21/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 19 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>			

DATE WHITE

Printer

14

See No. 1

Address not given

One shown for sale

Given 2 copies, 11

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8456

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 8456

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JAMES R. KLEIN</b>		2. DATE AND HOUR OF DEATH <b>August 17, 1968 5:05 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> C. CITY OR TOWN <b>BALTIMORE</b> E. STREET AND NUMBER <b>5715 BENTON HEIGHTS AV. 21206</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <b>M</b>	6. RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/25/1925</b>	9. AGE (In years last birthday) <b>42</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>Louis Klein</b>			12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 11</b>			16. SOCIAL SECURITY NO. <b>216-20-5468</b>		17. INFORMANT <b>Mrs Madeline M Klein</b>
18. <b>410.9 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CARDIAC ARREST.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ACUTE MYOCARDIAL INFARCTION</b> <b>ARTERIOSCLEROSIS CARDIOVASCULAR DISEASE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>70 minutes?</b> <b>2 hours?</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>420.1 II</b>					
19A. DATE OF OPERATION <b>8/20/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/17/68</b> 19 to <b>8/17/68</b> 19, that (I) (we) last saw the deceased alive on <b>8/17/68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Cesar A. Bravo</b>			23B. DATE SIGNED <b>8/17/68</b>		23C. PHYSICIAN'S NAME (Type) <b>CESAR A. BRAVO</b>
23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/21/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>	
24D. LOCATION <b>Baltimore, Maryland</b>					
25A. DATE REC'D AT HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Leonard J. Ruck</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc Baltimore, Md.</b>	

UNION MEMORIAL HOSPITAL

10/22/42 42

MARKER

CRASH REPORT

ROUTE MEDICAL INSURANCE  
ACTIVITIES REPORT

CELESTINE A. BRADY

UNION MEMORIAL HOSPITAL  
10/22/42

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8457. **CERTIFICATE OF DEATH**

REG. NO. 68- 8457

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Ignatius M. Benesch		August 18, 1968. 1:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
00 3708 White Avenue				Md. 22-34	
				C. CITY OR TOWN D. INSIDE CITY LIMITS	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				3708 White Avenue	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 9, 1885	83	U.S.A
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired Police Man Balto. City				Bohemia	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Joseph Benesch			Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		219-36-0806		Bertha M Benesch Same	
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>18. 412.4 I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>Cerebral hemorrhage</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>Arteriosclerotic C-V disease</p> <p>Assoc. Rt. hemiplegia</p> </div> </div>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
5 days					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
422.1 II Recurrent hemorrhagic duodenal ulcer 2 yrs					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) <del>(the hospital)</del> attended the deceased from <u>January 1957</u> to <u>Aug. 18, 1968</u> , that (I) <del>(was)</del> last saw the deceased alive on <u>Aug. 17, 1968</u> and that in (my) <del>(own)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(was)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
H.V. Harbold MD				Aug. 19, 1968	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
H.V. HARBOLD MD				4706 Harford Road Baltimore Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/22/68		Dulaney Valley	
		24D. LOCATION (City, town, or county)		24E. (State)	
		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 19 1968		Robert E. Sankara		Leonard J. Ruck, Inc. Balto. Md. 21214	

General Hospital

1111 11th Street, N.W.

(Corner 11th & N.W.)

General Hospital

Aug. 21 - 1918

H. V. HARRIS M.D.

H. V. HARRIS M.D.

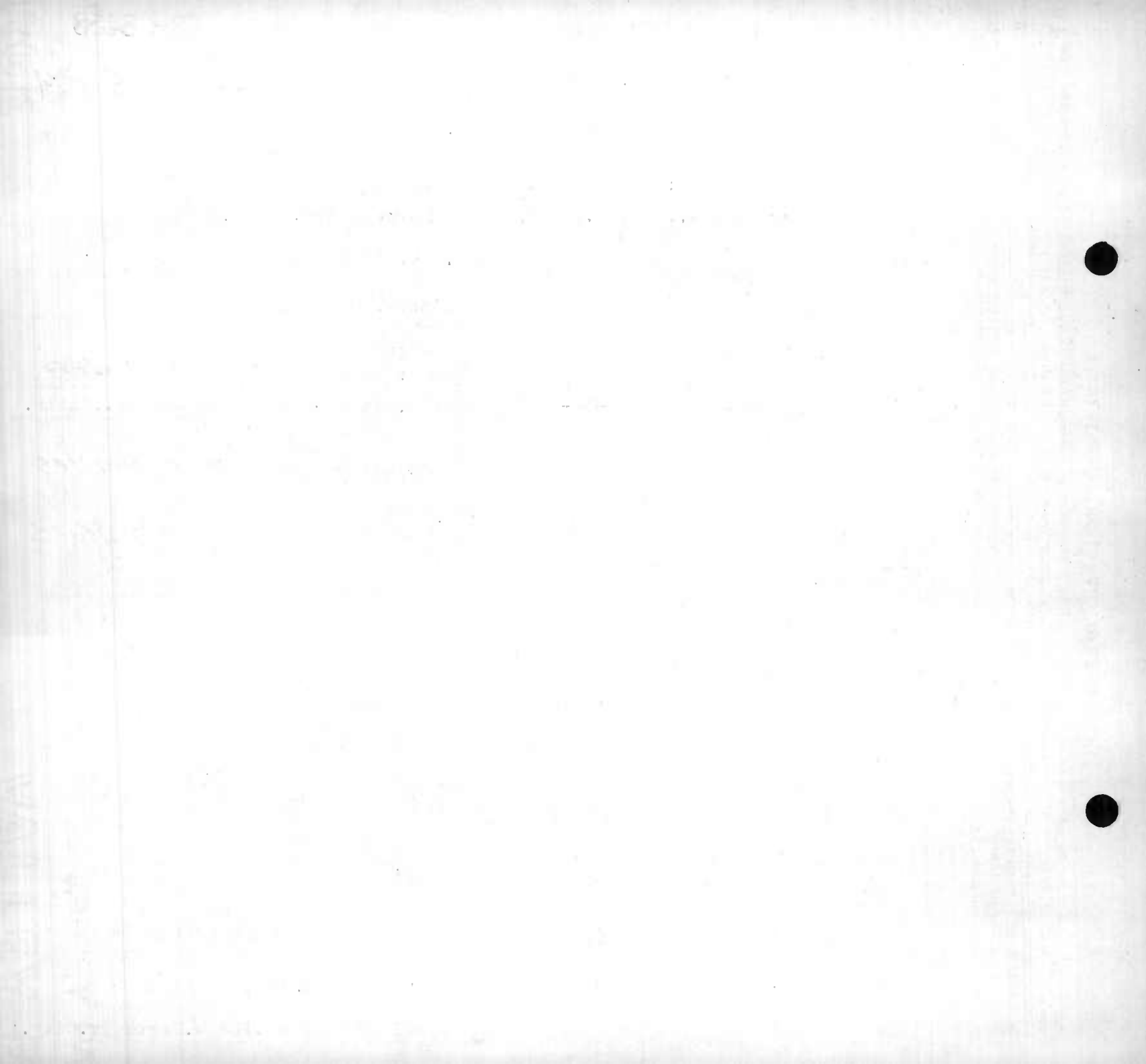
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 8458 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 8458

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JOHN MARTIN STREIMAN</b>		2. DATE AND HOUR OF DEATH <b>8-16-1968 8 AM M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 AT HIS RESIDENCE: 21212 614 Harwood Ave., Balto., XXXX</b>				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-48</b> C. CITY OR TOWN <b>City of Baltimore</b> INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>614 Harwood Ave. 21212</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 26, 1895</b>	9. AGE (In years lost birthday) <b>73</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retail sales</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Paint Company</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Martin Streiman</b>		
14. MOTHER'S MAIDEN NAME <b>Josephine ???</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW I 1</b>		
16. SOCIAL SECURITY NO. <b>212-01-1331</b>			17. INFORMANT: <b>wife</b> ADDRESS <b>21212 Pearl D. Streiman, 614 Harwood Av., Balto.</b>		
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>420.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Coronary Thrombosis</b> (B) <b>ASCDP</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>8 years</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/16</b> 19 <b>66</b> to <b>8/16/1968</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8-3-1968</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. J. Vitale M.D.</b> OEGREE				23B. DATE SIGNED <b>8/17/1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>William J. Vitale M.D.</b> OEGREE				23D. ADDRESS <b>6800 Loch Raven Blvd. 21204</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/19/1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		24E. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>			
24F. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		24G. FUNERAL DIRECTOR <b>STEWART &amp; MOWEN CO.</b>			
24H. ADDRESS <b>108 W. North Av. City. 1</b>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8459

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 8459

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Sister Stella Mullen

2. DATE AND HOUR OF DEATH

August 17, 1968 | 2:20 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)94  
Villa St. Michael  
4000 Forest Hill Road  
Baltimore, Md. 21207

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY City

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

4000 Forest Hill Road

5. SEX

F.

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

August 30, 1888

9. AGE (In years  
lost birthday)

79

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Bookkeeper-retired

10B. KIND OF BUSINESS OR INDUSTRY

Sister of Charity

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Arthur T. Mullen

14. MOTHER'S MAIDEN NAME

Annie C. McWilliams

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)  
No16. SOCIAL  
SECURITY NO.

219-54-0230-J1

17. INFORMANT

ADDRESS

Sister Andrea - same address

18.

410.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osthenio, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION lost.(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:  
Coronary occlusionAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

6 days

(B) General Arteriosclerosis  
DUE TO, OR AS A CONSEQUENCE OF:

7 years

(C)

420.1 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

None

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

None

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

None

21D. TIME  
OF INJURY  
(APPROX.)

None

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

None

22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

R. Nigrin

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

System

23B. DATE SIGNED

August 17, 1968

23C. PHYSICIAN'S  
NAME (Type)

Nigrin, Raphael, M.D.

DEGREE

23D. ADDRESS

8204 Scots Level Road, Balto. Md.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

burial

24B. DATE

8/19/68

24C. NAME OF CEMETERY or CREMATORY

Villa St. Michael Cem.

24D. LOCATION

(City, town, or county)

(State)

on grounds of Seton Inst.-6400 Wabash Av. Cityl

25A. DATE RECEIVED BY HEALTH DEPARTMENT

AUG 19 1968

25B. NAME OF REGISTRAR

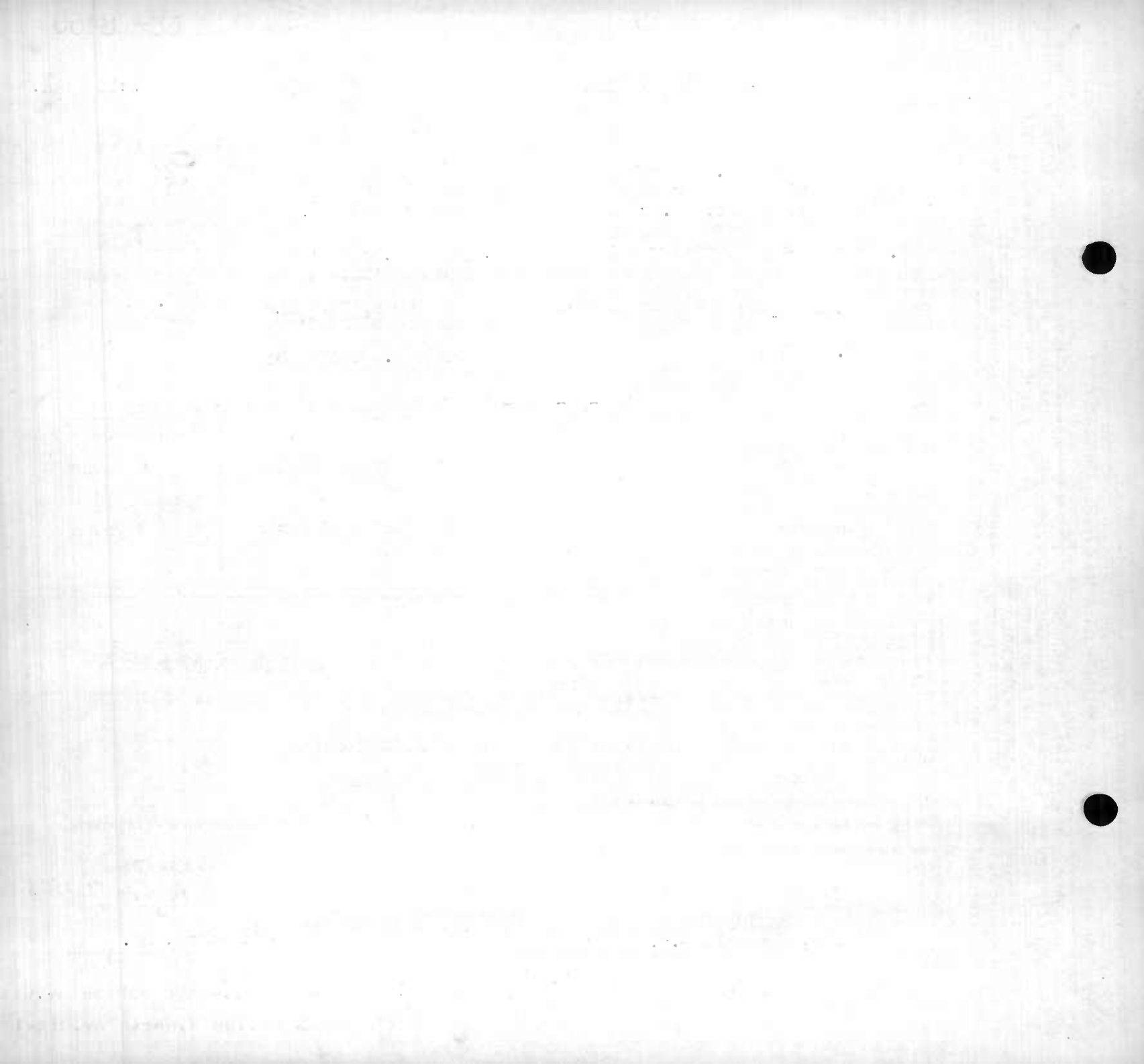
John E. Johnson

25C. FUNERAL DIRECTOR

STEWART &amp; MOWEN CO.

ADDRESS

108 W. North Av. Cityl



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-400		68-8460		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-8460					
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>JOHN F. Feehley</b>				2. DATE AND HOUR OF DEATH <b>8-15-68 4:30 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Baltimore City Hospitals</b>				C. CITY OR TOWN <b>Baltimore</b>				D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3/4940 Eastern Avenue Baltimore, Maryland #21224				E. STREET AND NUMBER <b>343 South Cornwall Street #21224</b>							
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-27-93</b>		9. AGE (In years lost birthday) <b>75</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Captain Balto. City Fire Dept.</b>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Michael Feehley</b>				14. MOTHER'S MAIDEN NAME <b>Laura Benser</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes - WWI</b>				16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>BCH Records: 4940 Eastern Avenue</b>				ADDRESS <b>Baltimore, Maryland #21224</b>	
18. <b>412.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrest</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>probable arrhythmia for myoz. infarction</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Atherosclerotic ht. disease</b>				days <b>few yrs.</b>			
19. <b>420.0 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <b>8-9</b> 19 <b>68</b> to <b>8-15-6</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8-14</b> 19 <b>68</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Lee J Cordova MD</b>								23B. DATE SIGNED <b>8/15/68</b>			
23C. PHYSICIAN'S NAME (Type) <b>LEE J. CORDOVA</b>								23D. ADDRESS <b>BCH: 4940 Eastern Ave. Balto MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/19/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. [unclear]</b>		25C. FUNERAL DIRECTOR <b>John J. Duda</b>		ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>					



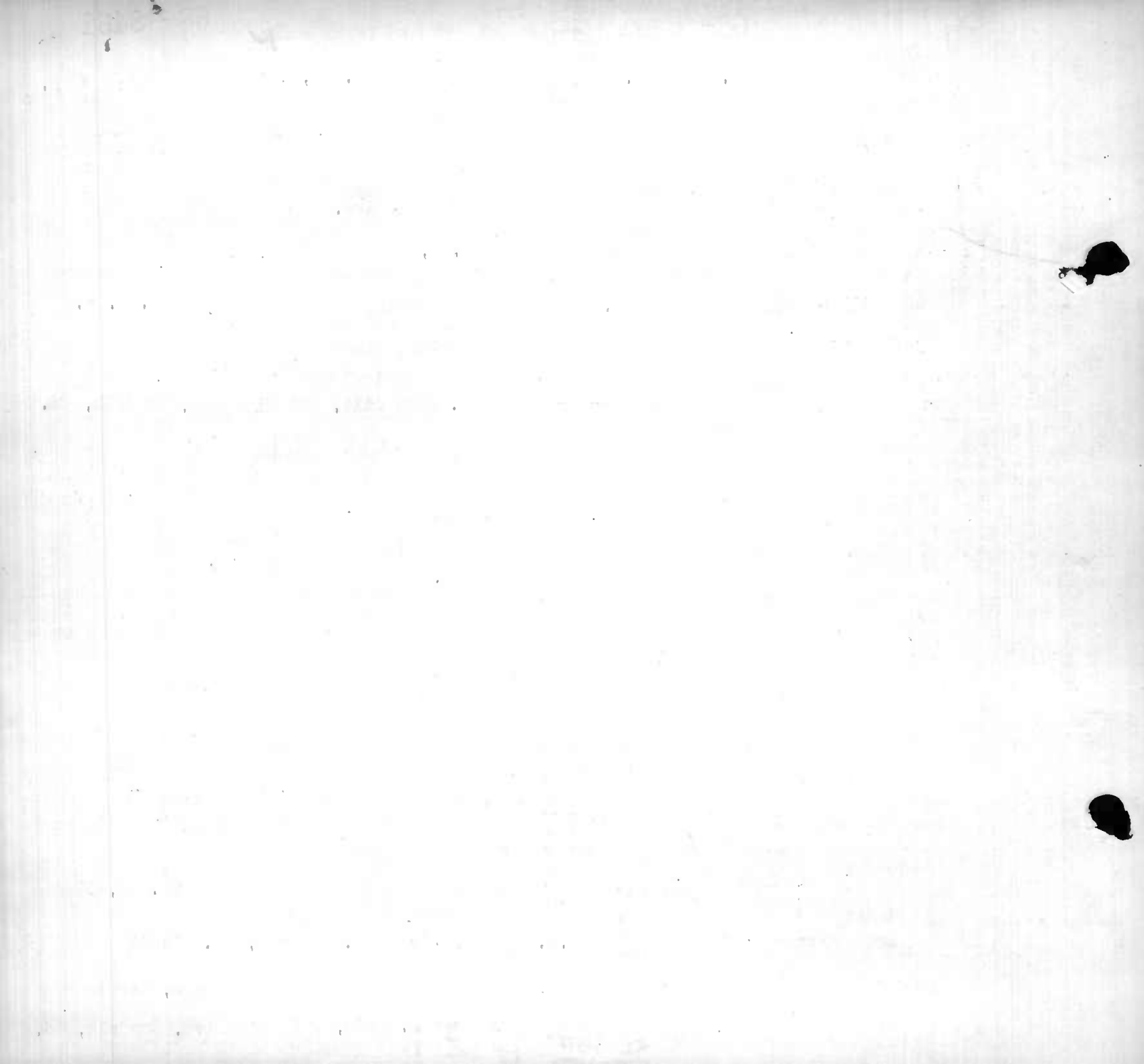
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8461 BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 8461

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Howard L. Gill Sr.</b>		2. DATE AND HOUR OF DEATH <b>Aug. 14, 1968</b> <b>8:54 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Baltimore City Hospital (DOA)</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> <b>53-00</b>		
			C. CITY OR TOWN <b>Dundalk</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER <b>802 Wise Ave.</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 1, 1924</b>	9. AGE (In years last birthday) <b>43</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>42" Mill - Bethlehem Steel Co.</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>George Gill</b>		
14. MOTHER'S MAIDEN NAME <b>Minnie Sherman</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		
16. SOCIAL SECURITY NO. <b>212-20-2815</b>			17. INFORMANT (Wife) <b>Mrs. Ruby Gill, 802 Wise Ave. Dundalk, Md.</b>		
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Coronary Sclerosis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. <b>420.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Feb 66</b> 19 to <b>Aug 7</b> 19 <b>68</b> that (I) (we) last saw the deceased alive on <b>Aug 7</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Marcos Levin</b>			23B. DATE SIGNED <b>Aug. 15, 1968</b>		
23C. PHYSICIAN'S NAME (Type) <b>Marcos Levin</b>			23D. ADDRESS <b>M.D. 201 Wise Ave. Dundalk, Md. 21222</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/19/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 19 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>John J. Duda</b>	
25D. ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68-8462	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) BENNETT, Douglas Alton				2. DATE AND HOUR OF DEATH 8/14/68 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Anne Arundel C. CITY OR TOWN Severna Park D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 202 Avondale Circle	
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6/10/19		9. AGE (In years last birthday) 49		10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10B. KIND OF BUSINESS OR INDUSTRY Electrical Const.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Alton Bennett		14. MOTHER'S MAIDEN NAME Clarice Crig (Craig)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 6/26/44 - 2/2/46 215-10-9723		17. INFORMANT VA Hospital Records & Mary Louise Bennett 3900 Loch Raven Blvd., Balto., Md 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) I.S.S. #213-16-9893 (9893) CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchogenic Carcinoma with metastases	
(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) DUE TO, OR AS A CONSEQUENCE OF:	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from July 12th 1968 to August 11th 1968, that (X) (we) last saw the deceased alive on August 11th 1968 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE RALPH H. TWINING, M.D.				23B. DATE SIGNED August 15, 1968	
23C. PHYSICIAN'S NAME (Type) RALPH H. TWINING, M.D.		23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 19/68		24C. NAME of CEMETERY or CREMATORY Oxford Cemetery	
24D. LOCATION (City, town, or county) Oxford, Maryland		(State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1968		25B. NAME OF REGISTRAR Robert E. Estabrook		25C. FUNERAL DIRECTOR Singleton Funeral Home Glen Burnie, Md.	

9/12/68 - Correction form from funeral director.

*JFC*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 68- 8463 CERTIFICATE OF DEATH

REG. NO. 68- 8463

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>HARRELL, ELLA CATHERINE</u>		2. DATE AND HOUR OF DEATH <u>AUGUST 13, 1968</u> <u>9:10 PM</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>34 BON SECOURS HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> , ANNE ARUNDEL Co. <u>52-00</u> C. CITY OR TOWN <u>GLEN BURNIE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>205 JUNIPER DRIVE</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 28, 1933</u>	9. AGE (In years last birthday) <u>35</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>LARKIN L. McCAM</u>		14. MOTHER'S MAIDEN NAME <u>SOPHIE QUANTMYER</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-28-2779</u>		17. INFORMANT <u>JOHN E. HARRELL - Samsoc #4</u>	
18. <u>438.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused the death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>334X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral edema</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>days</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>yes</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/9</u> 19 <u>68</u> to <u>8/13</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Aug. 13</u> at <u>9:10 PM</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Byong Hack Kim M.D.</u> DEGREE				23B. DATE SIGNED <u>8/13/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>BYONG HACK KIM M.D.</u> DEGREE		23D. ADDRESS <u>BON SECOURS Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Aug. 19, 1968</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat'l. Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 19 1968</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Glenn V. Hughes</u> ADDRESS <u>Glenn V. Hughes</u>			

1881

Wm. H. Brown

Wm. H. Brown

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8464 CERTIFICATE OF DEATH

REG. NO. 68- 8464

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BAILEY I R A . W .</b>		2. DATE AND HOUR OF DEATH <b>8-17-68 11:50 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> No <input type="checkbox"/>	
E. STREET AND NUMBER <b>3630 ELM AVENUE</b>					
5. SEX <b>M</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-02-87</b>	9. AGE (In years last birthday) <b>80 81yrs</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PENNA R.R.</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>V.S.A.</b>					
13. FATHER'S NAME <b>UNKNOWN Daniel Bailey</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN FOLE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No N/A</b>		16. SOCIAL SECURITY NO. <b>717-07-8156</b>		17. INFORMANT ADDRESS <b>MRS. ZOLA BAILEY-SAME</b>	
18. <b>5-82X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>UREMIC COMA?</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>CHRONIC RENAL FAILURE?</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>593X II</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-17-68</b> 19 <b>68</b> to <b>8-17</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8-17</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>A. Alvarez</b> M.D. DEGREE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>DR. MIRTHA ALVAREZ</b> M.D. DEGREE				23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-21-1968</b>		24C. NAME of CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REGISTRATION <b>8-20-68</b>		25B. NAME OF REGISTRAR <b>John E. Smith</b>		25C. FUNERAL DIRECTOR <b>Frank H. Seitz</b> ADDRESS <b>814 W 36th St</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8465	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>PALMER, VICTOR J.</b> a/k as Vincent V. Parker		2. DATE AND HOUR OF DEATH <b>8/18/68 2.40p.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1-05</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>36 FRANKLIN SQUARE Hosp.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RELIEF MAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Solderer Auto. Mfg.</b>		8. DATE OF BIRTH <b>6/27/09</b> 9. AGE (In years last birthday) <b>59</b>	
11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>BENEDICT PALMER</b>	
14. MOTHER'S MAIDEN NAME <b>CATHERINE O'CONNOR</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-01-5028</b>	
17. INFORMANT <b>AURELIA PALMER</b>		ADDRESS <b>2116 E. Lombard St.</b>		18. <b>15-7-91</b> CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>34</b>	
(B) <b>PANCREAS (CARCINOMA) - PANCREATITIS</b> DUE TO, OR AS A CONSEQUENCE OF:		(C) _____			
MEDICAL CERTIFICATION					
19. DATE OF OPERATION <b>157X</b> 20. AUTOPSY? (Yes or No) <b>II</b>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7/15</b> 19 <b>68</b> to <b>8/18</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>25th</b> <b>8/18</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Charles Kwon M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>8/18/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Charles Kwon M.D.</b>		23D. ADDRESS <b>FRANKLIN SQUARE Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/21/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Stanislaus</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 20 1968</b> 25B. NAME OF REGISTRAR <b>John E. Johnson</b>			
25C. FUNERAL DIRECTOR <b>B. F. SADOWSKI</b>		ADDRESS <b>&amp; SONS, 1808 EASTERN AVE.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8466

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 8466

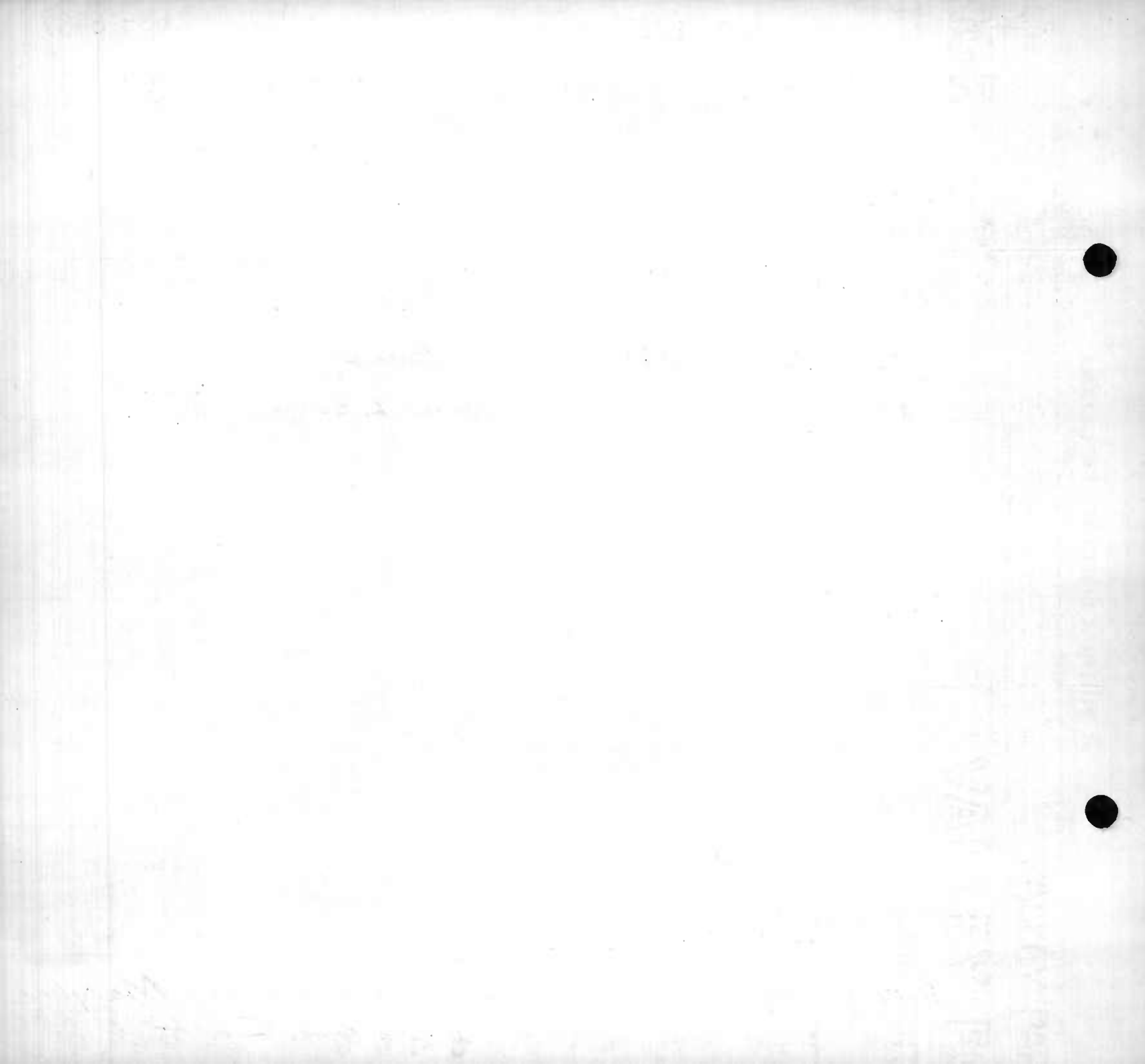
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Mr. ALBERT W. KOWALSKI</b>		2. DATE AND HOUR OF DEATH <b>August 17 1968 12:10 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> <b>53-00</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME AND HOSPITAL BALTIMORE, MARYLAND</b>			C. CITY OR TOWN <b>ESSEXORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER <b>916 GARDEN DRIVE (21)</b>		
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/23/1899</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MACH. OPER.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>WESTERN ELECTRIC</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICA</b>
13. FATHER'S NAME <b>EDWARD KOWALSKI</b>			14. MOTHER'S MAIDEN NAME <b>ANGELIN MACEK</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No -</b>		16. SOCIAL SECURITY NO. <b>212 09 1925</b>	17. INFORMANT <b>JULIA KOWALSKI</b>		ADDRESS <b>916 GARDEN DRIVE (21)</b>
18. <b>436.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>CEREBRO-VASCULAR ACCIDENT</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CEREBRO-VASCULAR ACCIDENT</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. DATE OF OPERATION <b>33/X II</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ABDOMINAL AORTIC ANEURYSM</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>August 1</b> 19 <b>68</b> to <b>August 17</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>August 17</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Corazon Z. Vergara, M.D.</b>			23B. DATE SIGNED <b>August 17, 1968</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>CORAZON Z. VERGARA, M.D.</b>			23D. ADDRESS <b>Church Home &amp; Hospital BALT. MD 2127</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8/20/68</b>	24C. NAME of CEMETERY or CREMATORY <b>Holy Rosary Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 20 1968</b>		25B. NAME OF REGISTRAR <b>Alma E. Tarkenton</b>	25C. FUNERAL DIRECTOR <b>Prudzinski Funeral Home</b> ADDRESS <b>1407 Eastern Ave.</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-6221		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	68- 8467
68- 8467		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Burgess, Nora H.</u>		2. DATE AND HOUR OF DEATH <u>4:55 pm 8/17/68</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>22-17</u>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital Beltsville + Gaithersburg, Md</u>		C. CITY OR TOWN <u>Balto</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>2731 Cyburn Ave.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>7/5/97</u>	9. AGE (In years last birthday) <u>71</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles Berger</u>		14. MOTHER'S MAIDEN NAME <u>Emma</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Walter L. Burgess - 2731 Cyburn Ave. Baltimore, Md 21215</u>	
18. <u>4-10-71</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Cardiac arrest</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarction</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>NSHD</u> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1-2 days</u> <u>Yrs.</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/17</u> <u>1968</u> to <u>8/17</u> <u>1968</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>8/17</u> <u>1968</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Jay Stephen Margolis MD</u> DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/17/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Jay Stephen Margolis</u> DEGREE		23D. ADDRESS <u>Sinai Hospital Balto, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>Aug 20, 1968</u>	24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Woodlawn Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 20 1968</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	25C. FUNERAL DIRECTOR <u>Wm Cook - Brooks Town</u>		ADDRESS <u>1050 York Rd Towson Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

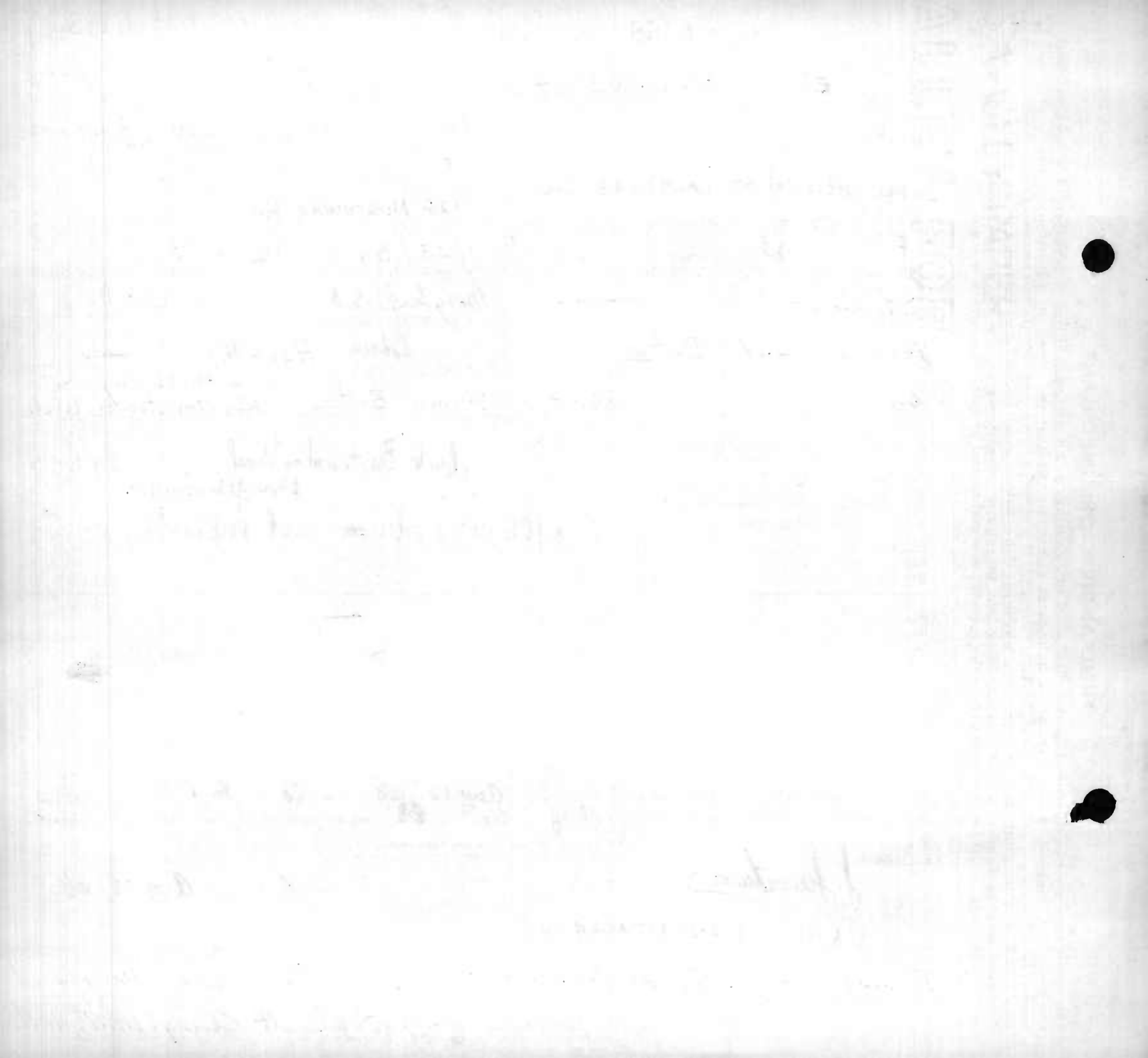
# BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 7

68- 8468

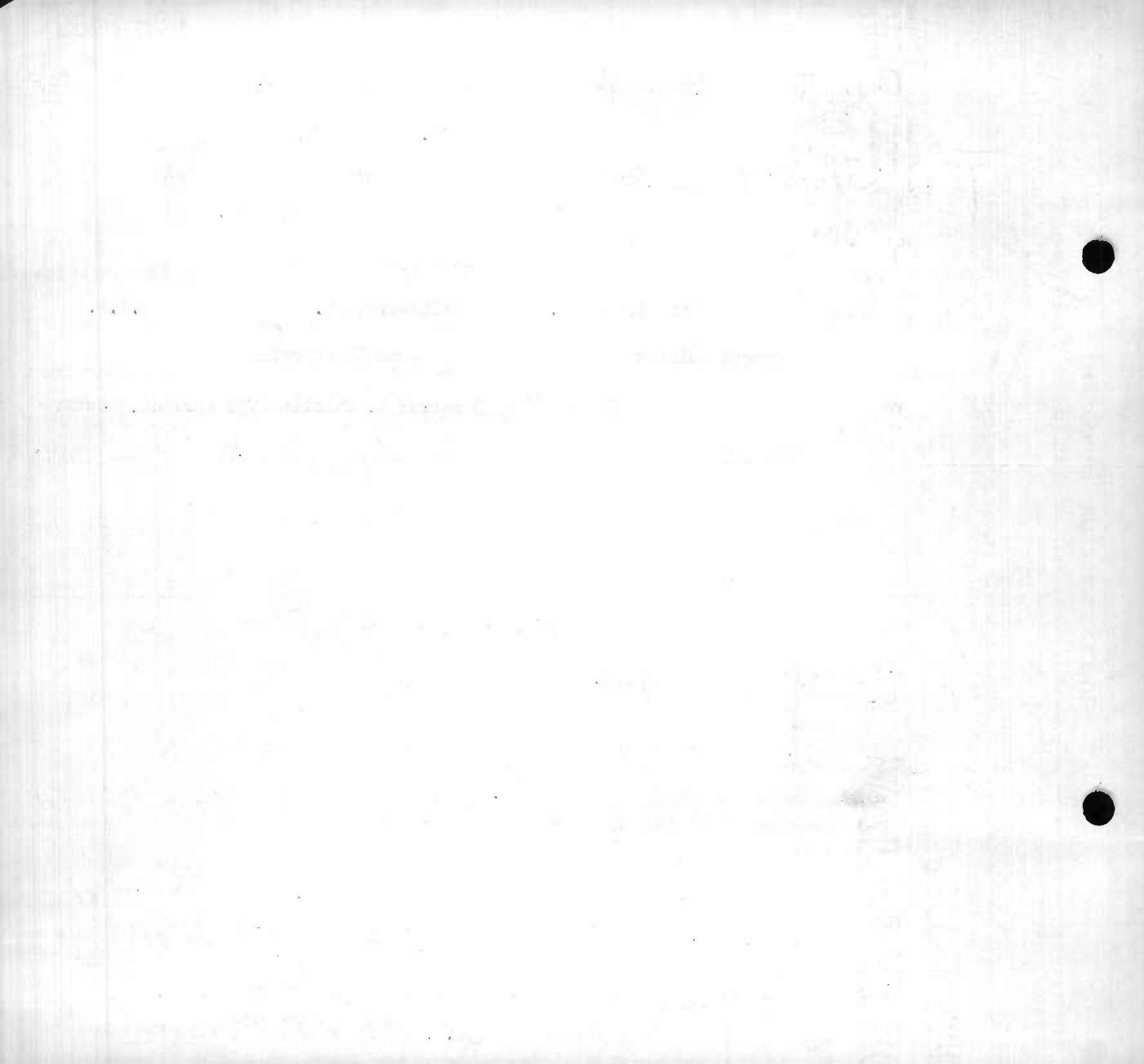
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Betz, CHARMAINE A</u>		2. DATE AND HOUR OF DEATH <u>Aug 16, 68</u> <u>1:20</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hospital of BALTIMORE Inc.</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Reisterstown. (BALTIMORE)</u>		
			C. CITY OR TOWN <u>REISTERSTOWN</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER <u>126 NORTHWAY Rd.</u>		<u>53-00</u>
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/25/56</u>	9. AGE (In years lost birthday) <u>12</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10B. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Maryland U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Vernon Paul Betz</u>			14. MOTHER'S MAIDEN NAME <u>Edna. Horak</u> <u>Same</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Vernon Betz</u>	
				ADDRESS <u>126 Northway Rd. Reisterstown, Md.</u>	
18. <u>464X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>474X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Acute Bacterial or Viral Pharyngobrachitis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>subglottis edema and Respiratory arrest.</u> (C) _____		
19A. DATE OF OPERATION <u>2</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 16, 68</u> 19 <u>68</u> to <u>Aug 16</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Aug 16</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. Lauentman</u> M.D.			23B. DATE SIGNED <u>Aug 16, 68</u>		23C. PHYSICIAN'S NAME (Type) <u>JAIME LAUENTMAN M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>Aug 19, 1968</u>		24C. NAME OF CEMETERY or CREMATORY <u>Gardens of Faith Cem.</u>
24D. LOCATION <u>Baltimore, Maryland.</u>			25A. DATE REC'D BY HEALTH DEPT. <u>AUG 20 1968</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>			25C. FUNERAL DIRECTOR <u>H. J. Schmitt</u>		
25D. ADDRESS <u>Cowings Mills, Md.</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8469
68- 8469 CERTIFICATE OF DEATH				
BIRTH NO.				
1. NAME OF DECEASED (Type or print) <i>Culotta Samuel</i>		2. DATE AND HOUR OF DEATH <i>8-14-68 3:50 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? <i>YES</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>4730 Park Heights Ave.</i>		
5. SEX <i>M</i>	6. RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12 2 1907</i>	9. AGE (In years last birthday) <i>60</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Foreman</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Fava Fruit Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>
13. FATHER'S NAME <i>Joseph Culotta</i>		14. MOTHER'S MAIDEN NAME <i>Lena Cinquargina</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217 03 8904</i>		17. INFORMANT <i>Margaret K. Culotta</i>
		ADDRESS <i>4730 Parl Heights Ave</i>		
18. <i>238.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Cardio respiratory arrest</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Brain Tumor</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>237X II</i>		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Mgo cardiac infarction</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>237X II</i>				
19A. DATE OF OPERATION <i>17-18-68</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>good</i>	20A. AUTOPSY? (Yes or No) <i>no</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <i>7-9</i> 19 <i>68</i> to <i>8-14</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>8-14</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>M. Nagasaka</i>		23B. DATE SIGNED <i>8-14-68</i>		23C. PHYSICIAN'S NAME (Type) <i>M. NAGASAKA</i>
23D. ADDRESS <i>SINAI Hospital of Baltimore</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>8/19/68</i>	24C. NAME OF CEMETERY or CREMATORY <i>Dulaney Valley Gardens</i>	24D. LOCATION (City, town, or county) (State) <i>Rockysville, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 20 1968</i>	25B. NAME OF REGISTRAR <i>Robert E. Stachura</i>	25C. FUNERAL DIRECTOR <i>J. E. Loyell Lemmon</i>		
		ADDRESS <i>4609 Park Hgts Ave</i>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68- 8470</b>
68- 8470				CERTIFICATE OF DEATH
BIRTH NO.		2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Mrs. Annie Ethel Greer</b>		8/16/68 10pm		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hosp.</b>		A. STATE <b>MD.</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44</b>		B. COUNTY <b>62-32</b>		
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH <b>5/29/91</b>		9. AGE (In years lost birthday) <b>77</b>		10. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>		11. BIRTHPLACE (State or foreign country) <b>W. Carolina</b>
13. FATHER'S NAME <b>Wiley Winton Osborne</b>		14. MOTHER'S MAIDEN NAME <b>Laura Betty Kilby</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-01-1656</b>		17. INFORMANT (Husband) <b>838-5985</b> ADDRESS <b>Roland Ave. &amp; Hall St. Bel Air, Maryland 21014</b>
18. <b>437,91</b>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE <b>Cerebral Vasc. Accident</b>		
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF: <b>Vasc. Dis.</b>		
ANTECEDENT CAUSES		(B) <b>Arteriosclerotic Cerebral Vasc. Dis.</b>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:		
331X II		(C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>June 18</b> 19 <b>68</b> to <b>Aug. 16</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Aug. 16</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Franklin Leslie, M.D.</b>		23B. DATE SIGNED <b>8/16/68</b>		23C. PHYSICIAN'S NAME (Type) <b>Franklin Leslie, M.D.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 19, 1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Bel Air Memorial Gardens</b>
24D. LOCATION (City, town, or county) (State) <b>Bel Air, Harford Co., Maryland 21014</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 20 1968</b>		
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</b>		

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8471 CERTIFICATE OF DEATH

REG. NO. 68- 8471

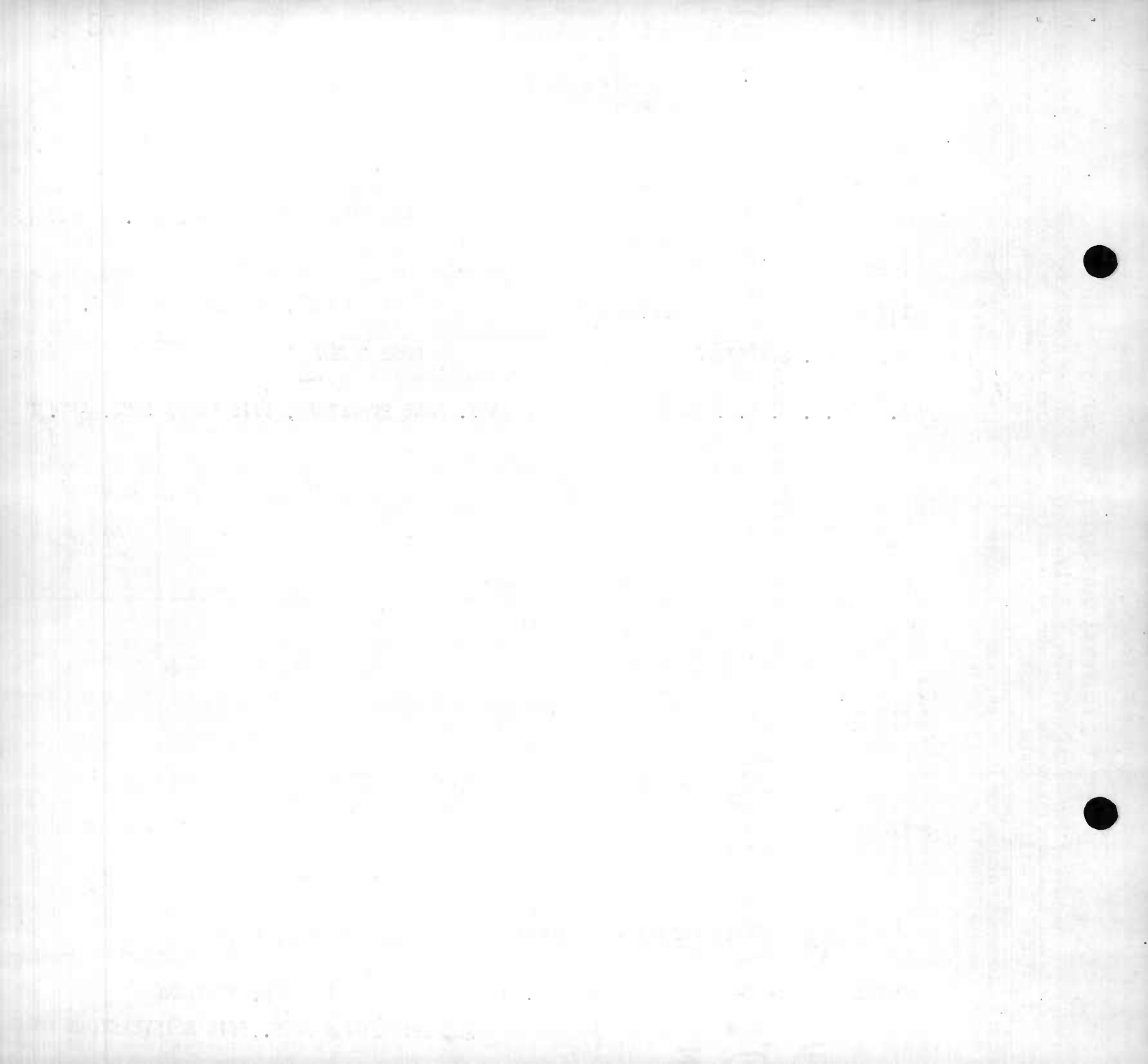
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Agnes C. Seaman</b>		2. DATE AND HOUR OF DEATH <b>August 14, 1968</b>   <b>3:20 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 Sinai Hospital of Baltimore, Inc.</b>			C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <b>4404 Daytona Avenue</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/17/87</b>	9. AGE (In years lost birthday) <b>80</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator (Retired) Textile</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Valentine Chmielewski</b>			14. MOTHER'S MAIDEN NAME <b>Marcyanna Nowakowski</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-10-4626A</b>		17. INFORMANT <b>Cecilia T. Seaman-4404 Daytona Ave</b>	
18. <b>560.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>massive pulmonary embolus</b> (B) <b>thrombus in leg veins</b> (C) <b>paralytic ileus</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>570.1 II atherosclerotic cardiovasc. disease</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 min</b> <b>less than week</b> <b>3 weeks</b> <b>20 years</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <b>July 26, 1968</b> to <b>August 14, 1968</b> , that (I) <del>last</del> saw the deceased alive on <b>August 14, 1968</b> and that in (my) <del>my</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> (did) <del>not</del> view the body after death.					
23A. SIGNATURE <b>Barry Dreen, M.D.</b>				23B. DATE SIGNED <b>8/14/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Barry Green M.D.</b>				23D. ADDRESS <b>Sinai Hospital of Baltimore, Inc.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/19/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Rosary Cemetery, Dundalk Md</b>	
24D. LOCATION (City, town, or county) (State) <b>Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 20 1968</b>			
25B. NAME OF REGISTRAR <b>R. E. F. F. F.</b>		25C. FUNERAL DIRECTOR <b>E. Lowell Lemmon</b>			
		ADDRESS <b>4611 Park Heights Ave.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

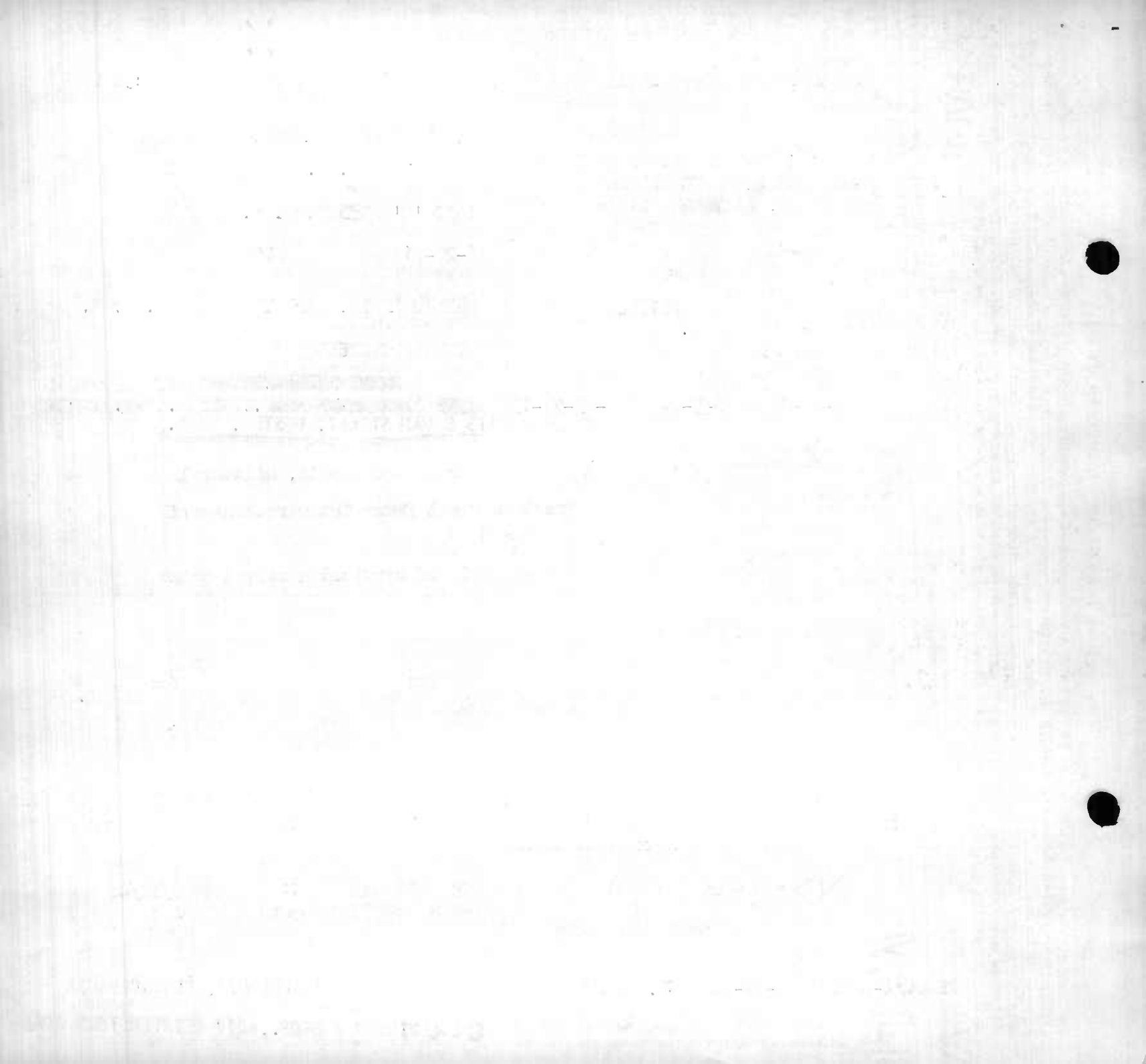
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8472	
BIRTH NO.		68- 8472		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print)		MILTON SCHREIBER		2. DATE AND HOUR OF DEATH 8/18/68 5:07 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY		27-20	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE	
				INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3712 FORDS LANE, APT. D #21215			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/22/02	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY POLICEMAN		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND U.S.A.	
13. FATHER'S NAME ABRAHAM J. SCHREIBER		14. MOTHER'S MAIDEN NAME ROSE ROSEN		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES. W.W. I. U.S. NAVY		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. ANNE SCHREIBER, 3712 FORDS LANE, APT. D	
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the made of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PULMONARY EDEMA 4-5 days X for HEPATIC DYSFUNCTION (B) BRONCHIOGENIC CARCINOMA METAS. 1-1 1/2 yrs DUE TO, OR AS A CONSEQUENCE OF: (C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 162.1 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/19/68 to 8/18/68 1968 to 8/18/68 1968. that (I) (we) lost saw the deceased alive on 8/18/68 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Karl Rosenfeld, M.D.		23B. DATE SIGNED 8/18/68		23C. PHYSICIAN'S NAME (Type) KARL ROSENFELD, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-20-68		24C. NAME OF CEMETERY or CREMATORY HEBREW FRIENDSHIP	
25A. DATE REC'D BY HEALTH DEPT. AUG 20 1968		25B. NAME OF REGISTRAR R. G. 2nd		25C. FUNERAL DIRECTOR SOC LEVINSON & BROS., 6010 REISTERSTOWN ROAD	
24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND		24E. ADDRESS		24F. ADDRESS	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 8473
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>SIMPSON, Alexander Melvin</b>		2. DATE AND HOUR OF DEATH <b>18 AUGUST 1968 6:50 P</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218</b>			C. CITY OR TOWN D. INSIDE CITY LIMITS? <b>DISTRICT OF COLUMBIA, WASHINGTON V-48 WASHINGTON D. C. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>		
			E. STREET AND NUMBER <b>1630 'R' STREET, N. W.</b>		
5. SEX <b>MALE</b>	6. RACE <b>CAUCASION</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-20-91</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HAIR STYLIST</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	11. BIRTHPLACE (State or foreign country) <b>PHILADELPHIA, PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>ALEXANDER SIMPSON</b>			14. MOTHER'S MAIDEN NAME <b>MINNA ROSENBERG</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 7-28-17 TO 6-7-19</b>		16. SOCIAL SECURITY NO. <b>106-03-79-13</b>	17. INFORMANT ADDRESS <b>ALEXANDER BEAL</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>723.0</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <b>15 BROAD STREET, BOSTON, MASS.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE <b>Bronchopneumonia, bilateral</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Fracture right femur intertrochanteric region</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Osteoporosis of cervical &amp; sacral spine</b> (C)		
19. DATE OF OPERATION <b>733.0 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			20A. AUTOPSY? (Yes or No) <b>Yes</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Yes</b>		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>21 JUNE 19 68</b> to <b>18 AUGUST 19 68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>18 AUGUST 19 68</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE <b>N. Bayadi, M.D.</b>			23B. DATE SIGNED <b>8/19/68</b>		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS <b>3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>REMOVAL-BURIAL</b>	24B. DATE <b>8-21-68</b>	24C. NAME of CEMETERY or CREMATORY <b>MT. SINAI</b>	24D. LOCATION (City, town, or county) (State) <b>PHILADELPHIA, PENNSYLVANIA</b>		
25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 20 1968</b>		25B. NAME OF REGISTRAR <b>W. E. B. B. B.</b>	25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 68- 8474 CERTIFICATE OF DEATH

REG. NO.

68- 8474

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>DORA GOLDSTEIN</b>		2. DATE AND HOUR OF DEATH <b>8-16-68</b> <b>9 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LEVINDALE HEBREW HOME AND INFIRMARY</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Levindale Hebrew Home and Inf. Balto, Md.</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>Levindale Aged Home 27-17</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1986</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Isaac Cohen</b>		
14. MOTHER'S MAIDEN NAME <b>Unknown</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <b>215-09-4371</b>			17. INFORMANT ADDRESS <b>Mr. Harry Abrams 2814 Hilldale Avenue #15</b>		
18. <b>4 10, 91</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <b>Acute myocardial infarction a few min.</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Atherosclerotic cardiovascular disease many years</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>420.1 II</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9-10-1963</b> to <b>8-16-1968</b> , that (I) (we) last saw the deceased alive on <b>8-16-1968</b> and that in (my) ( <del>the</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Agustin Collado</b>				23B. DATE SIGNED <b>8-16-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>AGUSTIN COLLADO M.D.</b>				23D. ADDRESS <b>Sinai Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/18/1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Aitz Chaim, Washington Blvd Baltimore, Maryland</b>	
24D. LOCATION (City, town, or county) (State)		25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 20 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. ...</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Sam Levinson &amp; Bros. Inc. 6010 Reisterstown Rd</b>			

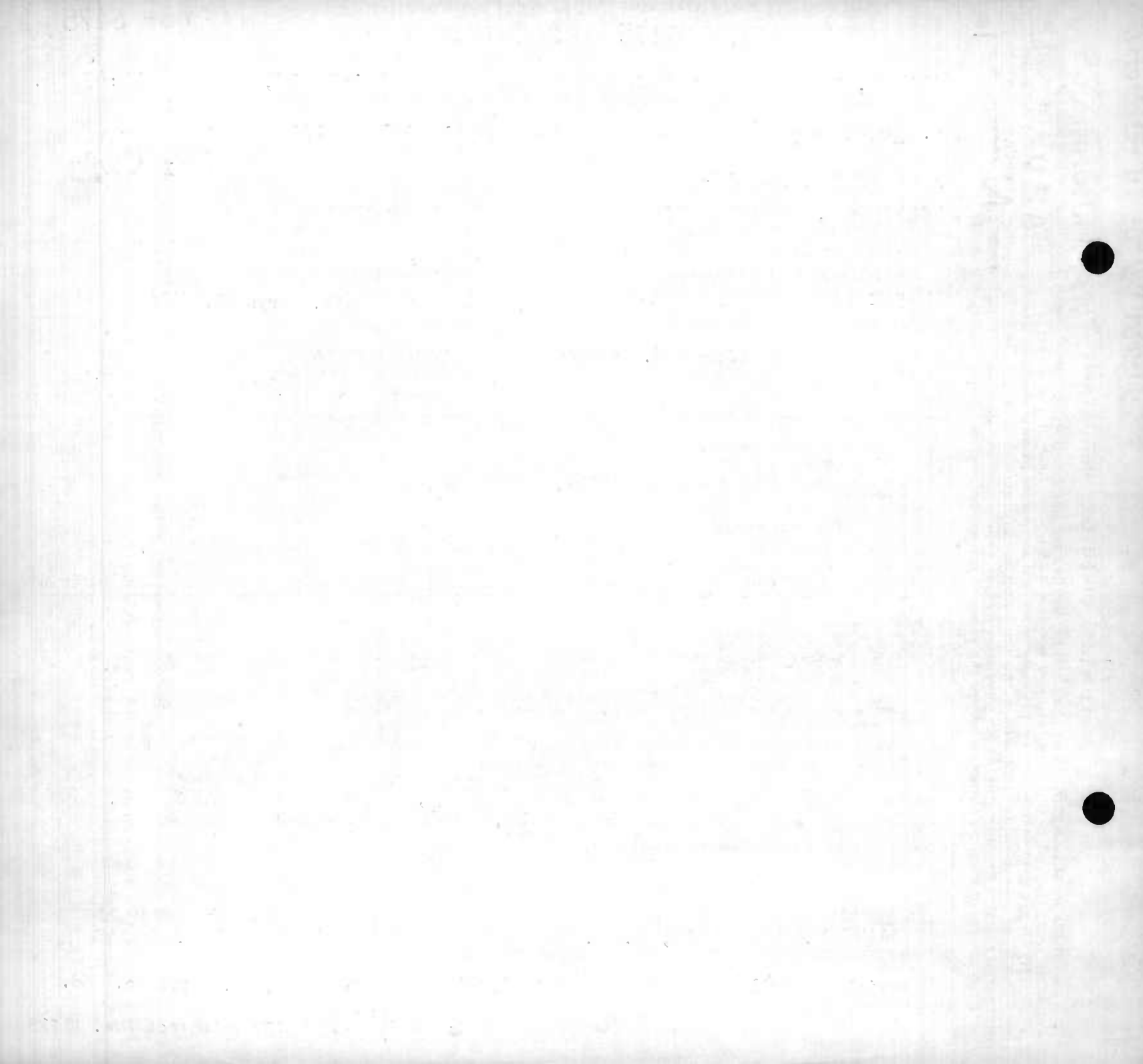


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 68- 8475 CERTIFICATE OF DEATH

REG. NO. 68- 8475

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>GRAVES, - MARY FLORENCE</b>		2. DATE AND HOUR OF DEATH <b>AUGUST 17, 1968 11:45 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>21230</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>WILKENS &amp; CATON AVENUE</b>			C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		
BALTIMORE, MARYLAND 21229			E. STREET AND NUMBER <b>2627 GEORGETOWN ROAD</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>02/08/88</b>	9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NURSES AID</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND (St. Marys Co.)</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>ALLIE THOMPSON (Joseph A. Thompson)</b>			14. MOTHER'S MAIDEN NAME <b>(LATHAM) CORA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>BALTIMORE, MARYLAND ADDRESS 21229 ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>		
18. <b>369.31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>uremia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>renal failure</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <b>renal failure</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>peritonitis 2° to small bowel fistula</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>578X II</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>8/15/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>small bowel fistula</b>	20A. AUTOPSY? (Yes or No) <b>NO</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (X) (this hospital) attended the deceased from <b>JUNE 29, 1968</b> to <b>AUGUST 17, 1968</b> , that (X) (we) last saw the deceased alive on <b>AUGUST 17, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (Y) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jaime V. del Pilar</b>			23B. DATE SIGNED <b>8/17/68</b>		23C. PHYSICIAN'S NAME (Type) <b>JAIME V. DEL PILAR, M. D.</b>
23D. ADDRESS <b>BALTIMORE, MARYLAND 21229 ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>			23E. FUNERAL DIRECTOR <b>237 Patapsco Ave. 21225</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8/21/68</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Bushwood, St. Marys Co. Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 20 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Edwards</b>	25C. FUNERAL DIRECTOR <b>McCallister</b>		



# FUNERAL DIRECTOR: IMPORTANT

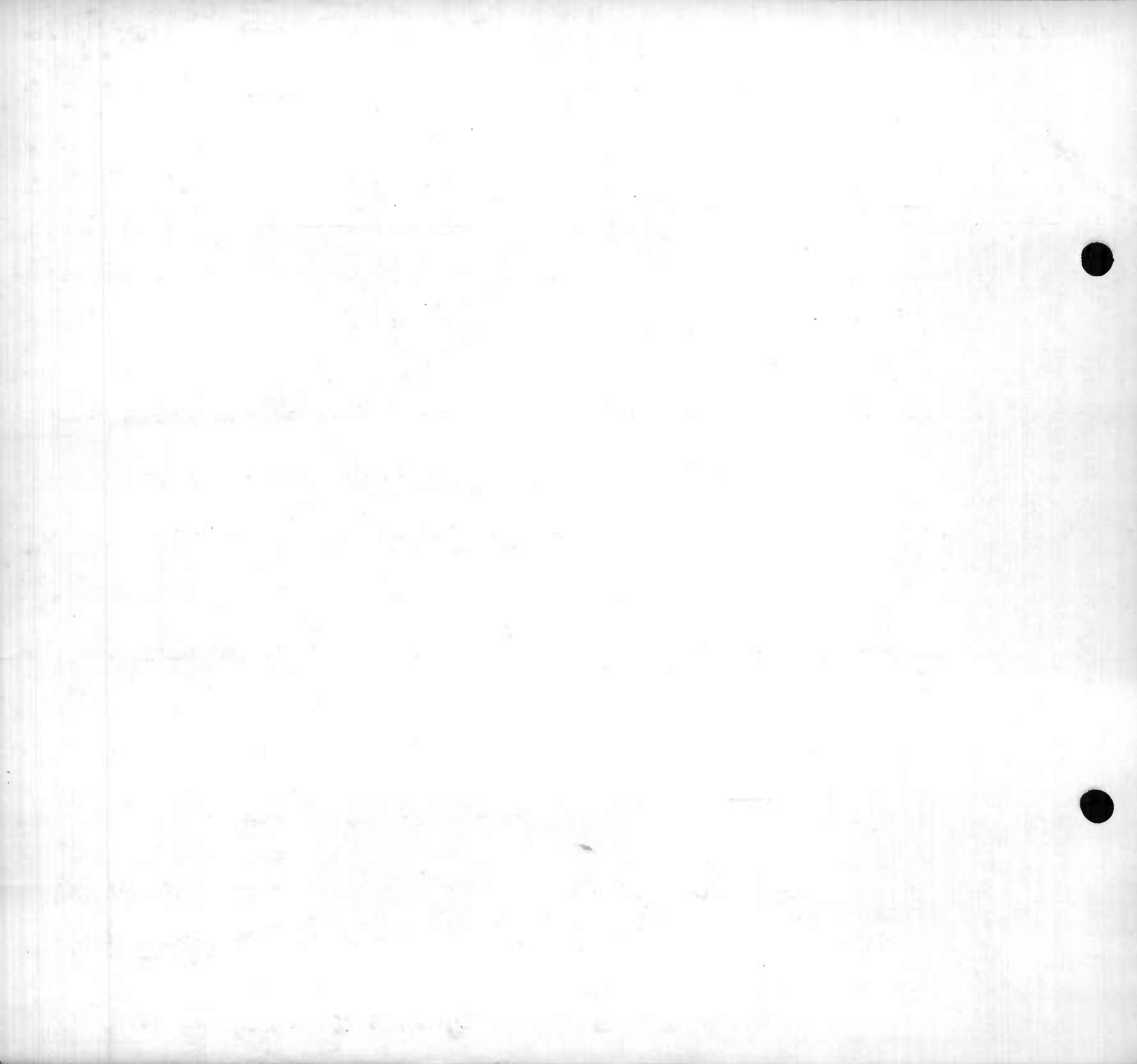
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 68- 8476 CERTIFICATE OF DEATH

REG. NO.

68- 8476

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BELLA L. GAFFEN</b>		2. DATE AND HOUR OF DEATH <b>Aug 16, 1968</b>   <b>3 P</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-20</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>3405 OLYMPIA AVE</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>3405 Olympia Ave</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-3-1907</b>	9. AGE (In years last birthday) <b>60</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Museum</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Halifax, Nova</b>	
13. FATHER'S NAME <b>Harry</b>			14. MOTHER'S MAIDEN NAME <b>Anna</b>		
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Miss Daisy Gaffen</b>	
				ADDRESS <b>Same</b>	
18. <b>403 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Renal failure</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>446 X II</b>			(B) <b>Nephrosclerosis &amp; pyelonephritis</b> years <b>Obesity</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>8/14 8/9</b> 19 <b>68</b> to <b>8/16</b> 19 <b>68</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>8/14 8/9</b> 19 <b>68</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ( <del>we</del> ) (did not) view the body after death.					
23A. SIGNATURE <b>Louis H Schaffer, MD</b>				23B. DATE SIGNED <b>8/17/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Louis H Schaffer MD</b>				23D. ADDRESS <b>222 W Gea Spring Lane, 21210</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/18/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Chapel Ameno</b>	
24D. LOCATION <b>Balto</b>		24E. STATE <b>Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 20 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Stalder</b>		25C. FUNERAL DIRECTOR <b>Schaffer &amp; Son, Inc</b>	
				ADDRESS <b>9610 Reisterstown Rd</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8477

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 8477

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

FROMENT, WILMER A.

2. DATE AND HOUR OF DEATH

AUGUST 17, 1968 10:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

ST. AGNES HOSPITAL

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

Baltimore 53-00

C. CITY OR TOWN

BALTIMORE 21228

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

601 ARLEWOOD RD.

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

04-26-80

9. AGE (In years lost birthday)

88

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

ELECTRICIAN

10B. KIND OF BUSINESS OR INDUSTRY

RET.

11. BIRTHPLACE (State or foreign country)

INDIANA

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

ELLIOTT FROMENT

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

307054468A

17. INFORMANT

AVES. BALTO MD.

ST. AGNES HOSP. RECORDS-CATON & WILKENS

18. 412.31

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Atherosclerotic Heart Disease

(B) DUE TO, OR AS A CONSEQUENCE OF:

Acute Pulmonary Edema

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from AUGUST 17, 1968 to AUGUST 17, 1968, that (I) (we) last saw the deceased alive on AUGUST 17, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

08 18 68

23C. PHYSICIAN'S NAME (Type)

SALVADOR QUIROZ, M.D.

DEGREE

23D. ADDRESS

BALTIMORE, MD 21229

ST AGNES HSP WILKENS & CATON AVENUE

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

8/21/68

24C. NAME OF CEMETERY or CREMATORY

ROSELAWN

24D. LOCATION

(City, town, or county)

(State)

TERRE HAUTE IND.

25A. DATE REC'D BY HEALTH DEPT.

AUG 20 1968

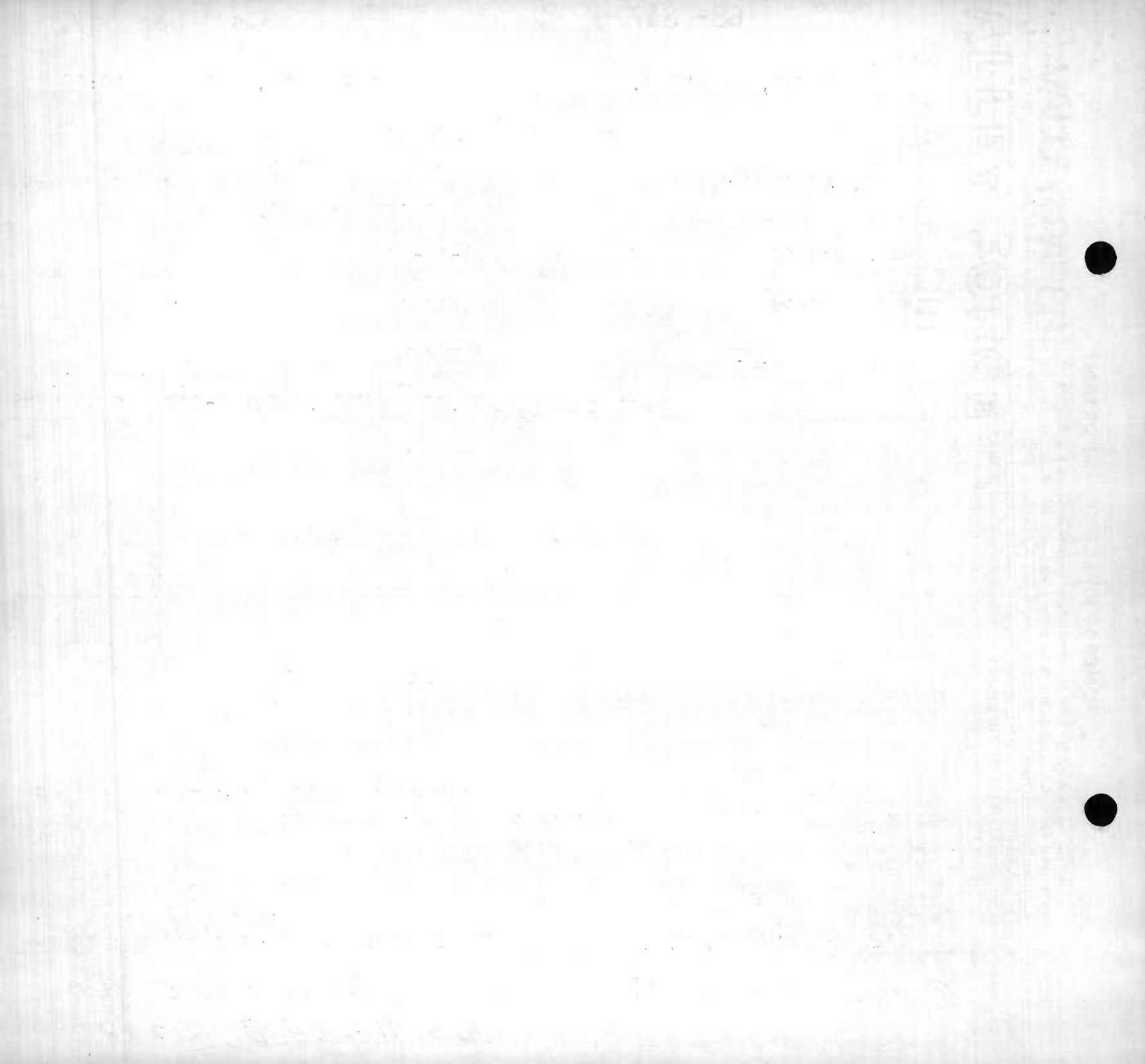
25B. NAME OF REGISTRAR

Robert E. Gentry

25C. FUNERAL DIRECTOR

51 MAX NABB 21228

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8478

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 8478

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Ora N. Humbert

2. DATE AND HOUR OF DEATH

Aug. 16, 1968

12:10 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)House of the Pines-Belvedere  
2525 W. Belvedere Avenue  
Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
B. COUNTY  
Maryland 21212

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

5510 Craig Avenue

5. SEX

Female

6. RACE

White

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

June 18, 1893

9. AGE (In years  
last birthday)

75

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

---

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

David Currens

14. MOTHER'S MAIDEN NAME

Mary Hawk

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

---

16. SOCIAL  
SECURITY NO.

213-03-3245

17. INFORMANT

ADDRESS

Oscar J. Humbert (Husband) Same

18.

153.81

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE Adenocarcinoma of colon  
DUE TO, OR AS A CONSEQUENCE OF:

4 years

xxx with widespread metastasis

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

D

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At  
Work ☐Not White  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from 19 61 to Present 19 ,  
that (I) ~~(we)~~ last saw the deceased alive on August 15 1968 and that in (my) ~~(our)~~ opinion death occurred on the date  
and hour and from the causes stated above. (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

23A. SIGNATURE

W. H. Townshend, Jr.

DEGREE

Attending  
Phys. ☒Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

8-17-68

23C. PHYSICIAN'S  
NAME (Type)

W. H. Townshend, Jr.

DEGREE

23D. ADDRESS

14 E. Eager Street Baltimore, Md.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8/19/1968

24C. NAME OF CEMETERY or CREMATORY

Kriders Cemetery

24D. LOCATION

(City, town, or county)

(State)

Westminster, Md.

25A. DATE RECEIVED BY HEALTH DEPT

AUG 20 1968

25B. NAME OF REGISTRAR

Robert E. Gubins

25C. FUNERAL DIRECTOR

Eugenia K. Seitz 5209 York Rd.

ADDRESS

Seitz Funeral Home Baltimore 2 1212

AMERICAN COLLEGE

NEW YORK, N. Y.

1912

August 12, 1912

1912-13

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 8479

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

CLYDE

GREGORY

TUCKER

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

August 9, 1968

2:00 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

ST. AGNES HOSPITAL (DOA)

3. DATE  
PRONOUNCED DEAD

August 9, 1968

2:00 A.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Missouri

B. COUNTY

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

SILOAM SPRINGS

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Sept 29, 1928

10. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

Twin Bridges Siloam Springs Missouri

11. BIRTHPLACE (State or foreign country)

Piedmont Alabama

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Clarence E. Tucker

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

construction

15. MOTHER'S MAIDEN NAME

Gladyce C. Chandler

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

Dale Watson 13024 Old Stagecoach Rd. Ind.

19. E 812.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Multiple Traumatic Injuries

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

E 816.1

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Intersection of Gorman Rd. and U.S. Rte. #1

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.) August 9, 1968 1:15 A.M.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Passenger in auto-truck collision

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 9, 1968

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8/12/68

24C. NAME OF CEMETERY or CREMATORY

Inmans Cemetery

24D. LOCATION (City, town, or county) (State)

Twin Bridges, Mo.

25A. DATE REC'D BY HEALTH DEPT

AUG 20 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Raymond J. Purnell

ADDRESS

Ind.

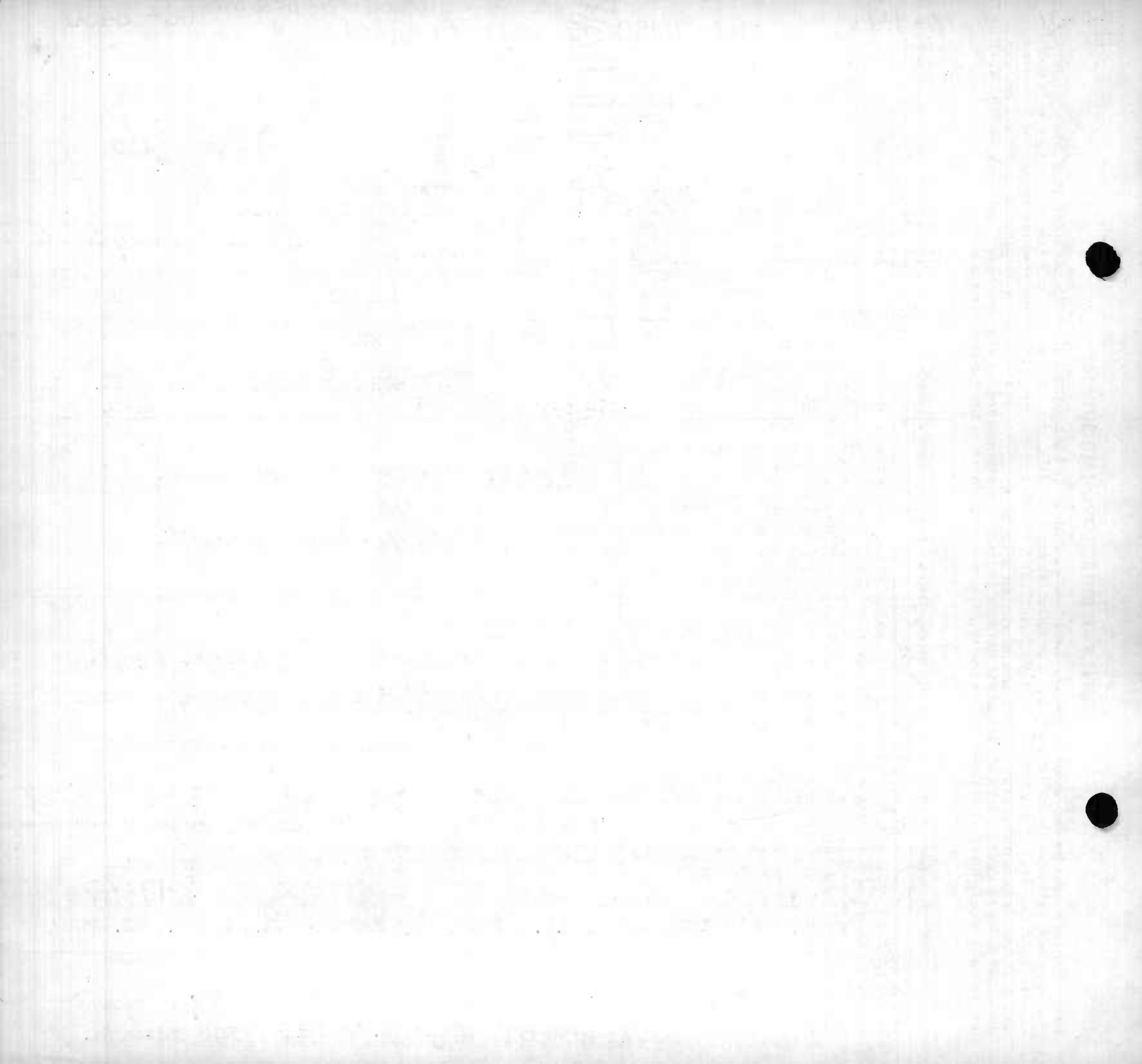
823-1

2

VALLEY BOTTOM

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 8480	
1. NAME OF DECEASED (Type or Print) <b>BARBARA Vaupel</b>		2. DATE AND HOUR OF DEATH <b>6:00am 8-17-68</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND 21224</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
		E. STREET AND NUMBER <b>6200 ALUMORE WAY 21224</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-21-87</b>	9. AGE (In years lost birthday) <b>80</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JACOB</b>		14. MOTHER'S MAIDEN NAME <b>ROSE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-05-5633</b>		17. INFORMANT <b>BCH 4940 EASTERN AVE., BALTO., MD. 21224</b>	
18. <b>309.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Aspiration Pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic Brain Syndrome</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>309X II</b>					
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8-23 1967</b> to <b>8-17 1968</b> , that (I) (we) lost saw the deceased alive on <b>8-16-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>R. Christopher Stucky</b>		23B. DATE SIGNED <b>8-17-68</b>		23C. PHYSICIAN'S NAME (Type) <b>R. CHRISTOPHER STUCKY M.P.</b>	
23D. ADDRESS <b>BCH: 4940 EASTERN AVE., BALTO., MD. 21224</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8-20-68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Schwartz's</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 20 1968</b>	25B. NAME OF REGISTRAR <b>Robert E. Stucky</b>	25C. FUNERAL DIRECTOR <b>Thelma A. Hoffmann</b>		ADDRESS <b>3218 Hudson St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8481

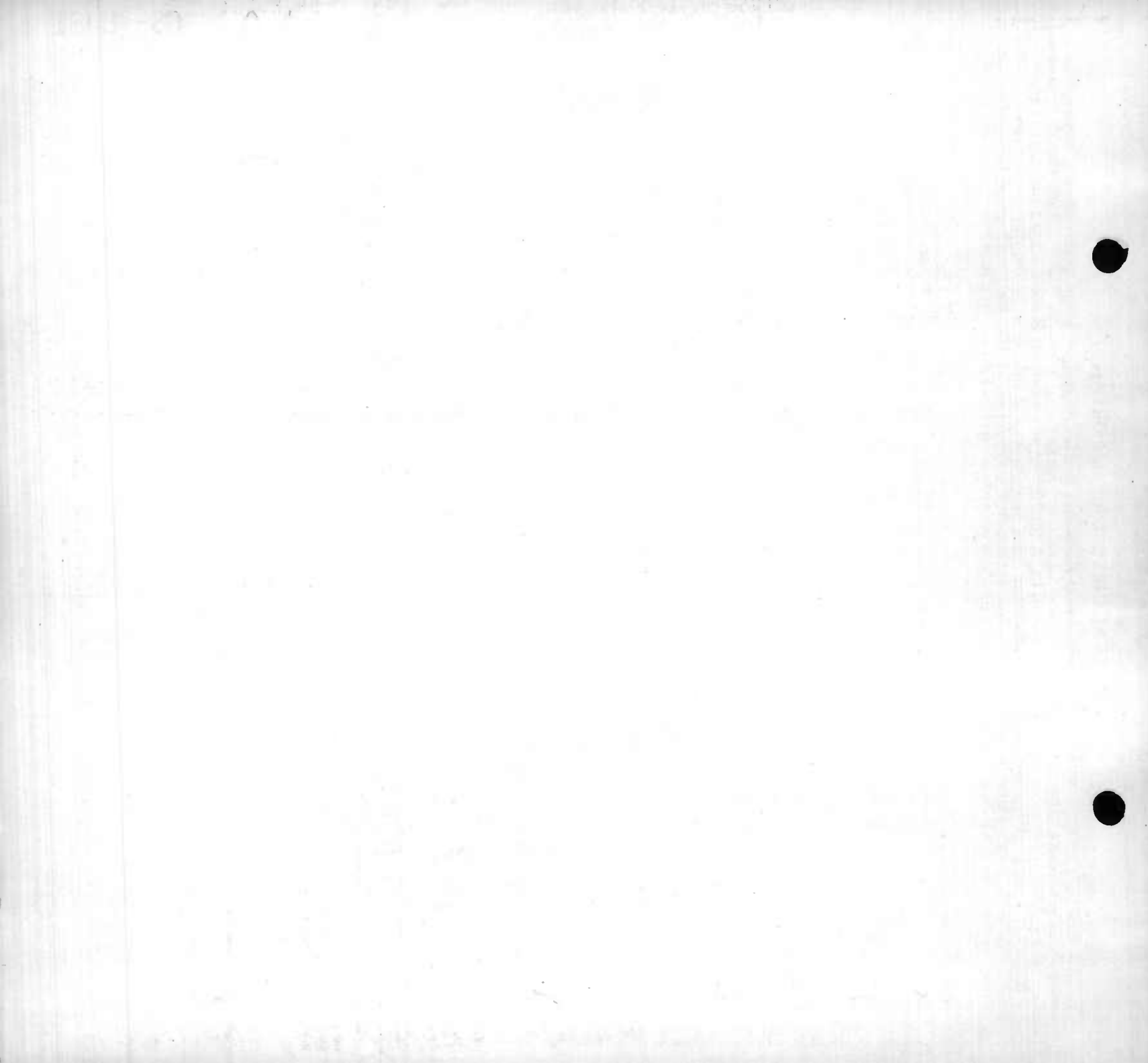
## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

DR. KOSKI

REG. NO.

68- 8481

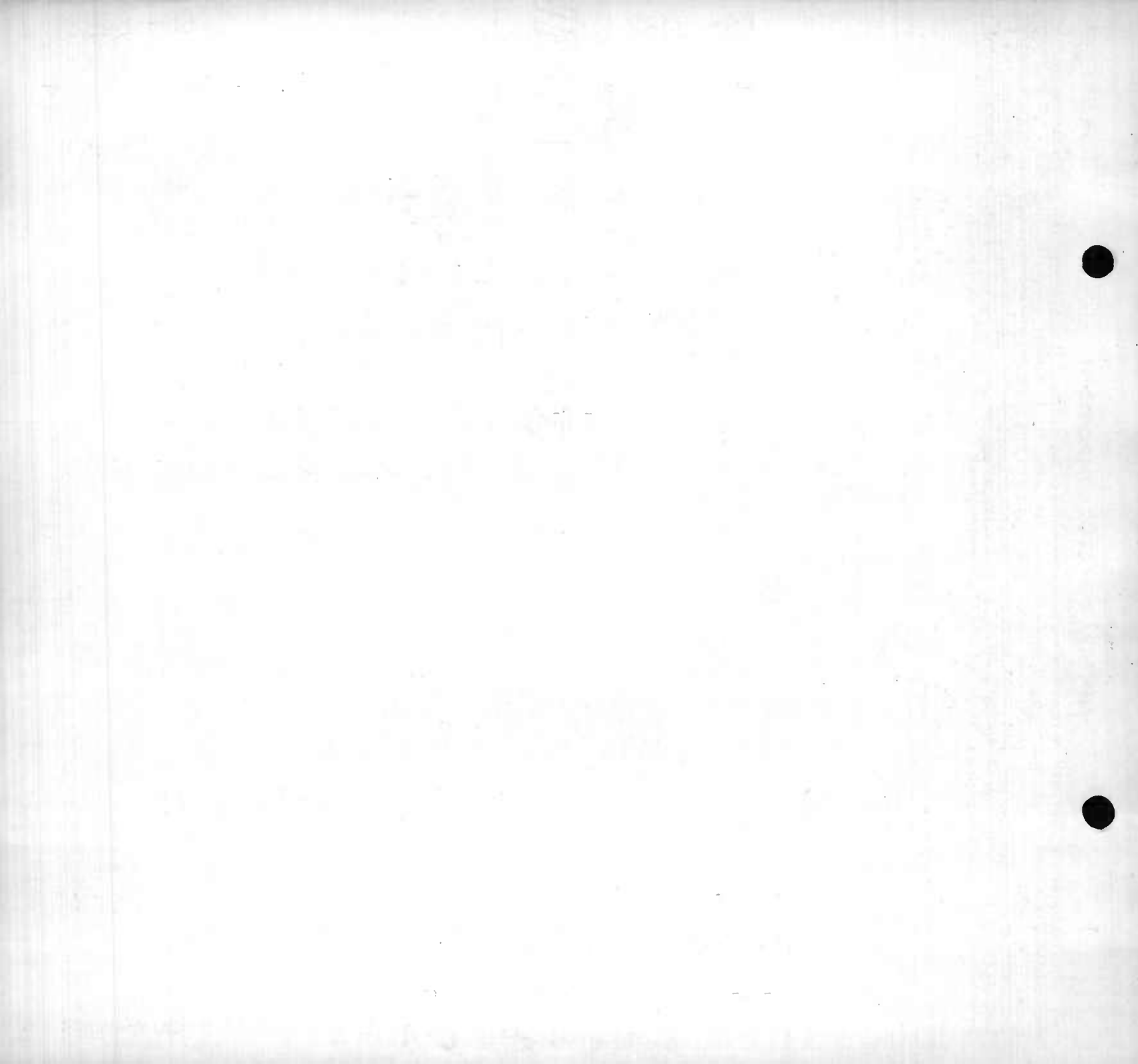
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>LILLIAN ADA SMITH</b>		2. DATE AND HOUR OF DEATH <b>18 AUGUST 1968</b> <b>11 20 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 UNIVERSITY OF MARYLAND HOSPITAL</b>			C. CITY OR TOWN <b>BALTO.</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>221 WESTOWNE ROAD.</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-28-15</b>	9. AGE (In years last birthday) <b>52</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED US GOVT INT. REV. SERVICE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>WALTER SMITH</b>			
14. MOTHER'S MAIDEN NAME <b>LILLIAN HOLMES</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO NO</b>			
16. SOCIAL SECURITY NO. <b>216-44-4201</b>		17. INFORMANT <b>G. WALTER SMITH 505 KINGSTON RD</b>			
18. <b>484X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonitis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic lung disease.</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>492X II</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>29 JULY 19 68</b> to <b>18 AUGUST 19 68</b> , that (1) (we) last saw the deceased alive on <b>18 AUGUST 19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jean M. Jackson, M.D.</b>				23B. DATE SIGNED <b>18 AUGUST 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>JEAN M. JACKSON, M.D.</b>				23D. ADDRESS <b>BALTIMORE, MARYLAND 21201 UNIVERSITY OF MARYLAND HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>9/21/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>LOUDON PARK</b>	
24D. LOCATION <b>BALTO. MD.</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 20 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>STANLEY BORY 6411 WINDSOR MILL</b>	
25D. ADDRESS					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8482	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>EVELYN E. LOMAGRO</b>		2. DATE AND HOUR OF DEATH <b>8-17-68 12.30</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>34 Bon Secours Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Female</b>		6. RACE <b>Cauc.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N. A.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Casualty Co</b>		8. DATE OF BIRTH <b>12-22-01</b> 9. AGE (In years last birthday) <b>66</b>	
13. FATHER'S NAME <b>LOUIS KULACKI</b>		14. MOTHER'S MAIDEN NAME <b>PAULINE KRYGIER</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-18-3831</b>		17. INFORMANT <b>CHART - PATIENT</b> ADDRESS	
18. <b>410.9 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>420.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Myocardial Infarct Days</b> <b>A.S.C.V.D. YEARS</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-7-68</b> to <b>8-17-68</b> , that (I) (we) last saw the deceased alive on <b>8-17-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Agustin del Campo MD</b>				23B. DATE SIGNED <b>8-17-1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>AGUSTIN del Campo</b>		23D. ADDRESS <b>Bon Secours, BALTO. Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-20-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>St Stanislaus Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 20 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>WALTER DABROWSKI</b>	
				ADDRESS <b>1005 DUNDALK AVENUE</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

## 68- 8483 CERTIFICATE OF DEATH

REG. NO. 68- 8483

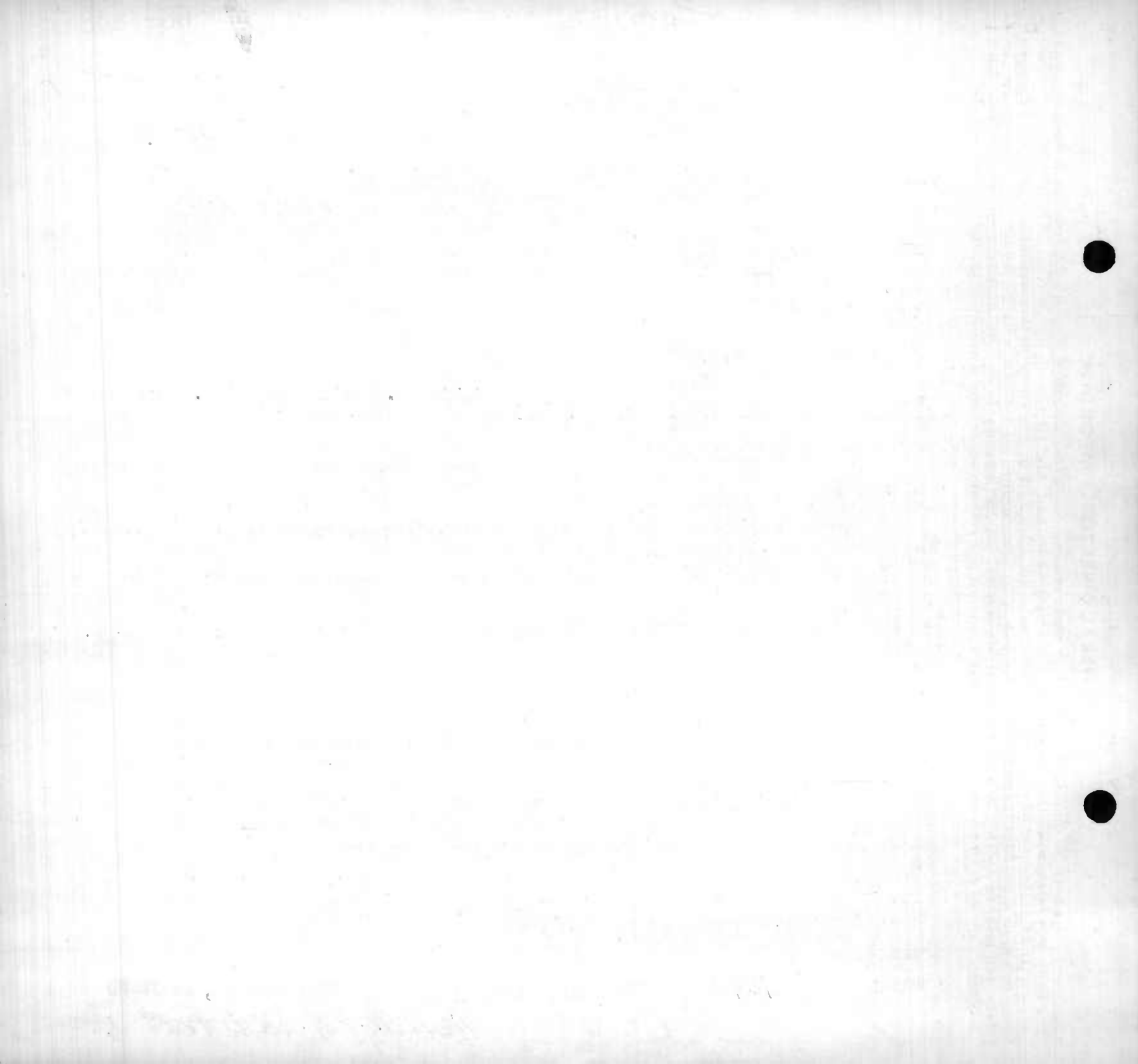
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ANDERSON, Nannie Virginia</b>		2. DATE AND HOUR OF DEATH <b>8-16-68</b>   <b>8:05</b> P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>District of Columbia</b> B. COUNTY <b>V-48</b> C. CITY OR TOWN <b>Washington</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1901 Wyoming Avenue N W</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>					
5. SEX <b>Female</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-14-83</b>	9. AGE (In years last birthday) <b>85</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Clear Spring, Maryland</b>	
13. FATHER'S NAME <b>John Anderson</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Brenan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) <b>Yes 1-5-18 to 7-4-19</b>		16. SOCIAL SECURITY NO. <b>232-80-40-40</b>		17. INFORMANT <b>VA Hospital Records</b> ADDRESS <b>3900 Loch Raven Blvd, Balto, Md 21218</b>	
18. <b>712.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>442X II</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE (GENERALIZED)</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>ARTERIAL &amp; ARTERIOLAR NEPHROSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>(MARRIED LFT, MOD. RT. KIDNEY)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>442X II</b>		INTESTINAL OBSTRUCTION, DISTAL ILEUM			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>X</b> (this hospital) attended the deceased from <b>July 23, 19 68</b> to <b>August 16, 19 68</b> , that <b>X</b> (we) last saw the deceased alive on <b>August 16, 19 68</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>X</b> (We) (did) <b>not</b> view the body after death.					
23A. SIGNATURE <b>Ronald C. Elkins, MD</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>8-17-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>RONALD C. ELKINS, MD</b>		23D. ADDRESS <b>3900 LOCH RAVEN BOULEVARD</b> <b>BALTIMORE, MARYLAND 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>8/21/68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Balto. National</b>		24D. LOCATION (City, town, or county) (State) <b>Balto MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 20 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Geo. T. S. Davis</b> ADDRESS <b>8802 Harford Rd</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

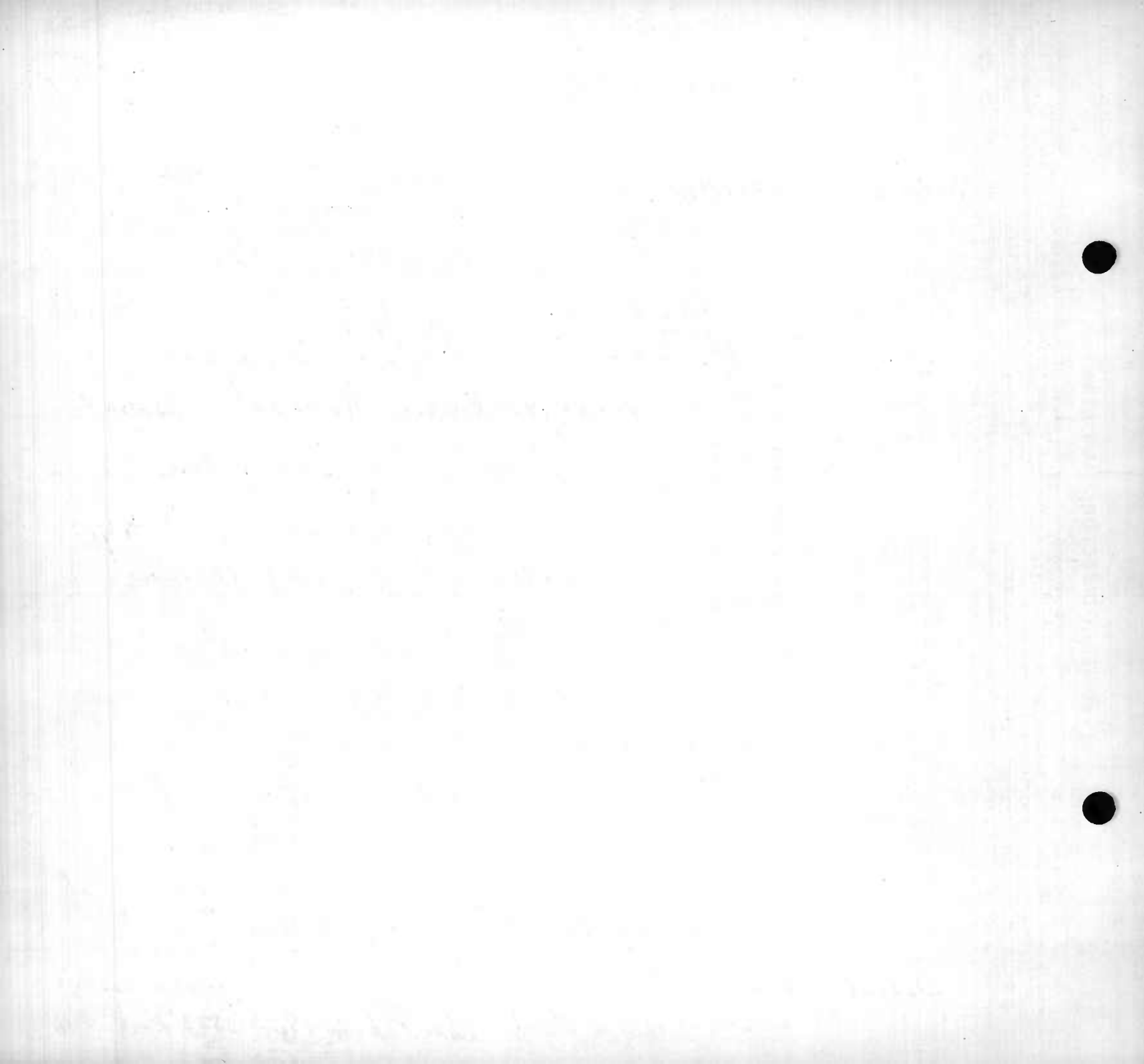
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 8484	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>IDA M. STRICKLAND</u>		2. DATE AND HOUR OF DEATH <u>8/17/68</u> <u>444</u> P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>23-501</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>SOUTH BALTIMORE GENERAL</u> <u>43</u>			C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <u>108 W. FORT AVE</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 3, 1891</u>		9. AGE (In years last birthday) <u>77</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
13. FATHER'S NAME <u>WILLIAM TURNER</u>			14. MOTHER'S MAIDEN NAME <u>?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217 07 8853</u>		17. INFORMANT <u>William R. Strickland</u> <u>JOHN E. FRIZZERA</u>	
			ADDRESS <u>108 W. Fort Avenue</u>		
18. <u>436.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>MASSIVE COLLAPSE OF LUNG</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>TENSION PNEUMOTHORAX</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) <u>CEREBRAL VASCULAR ACCIDENT</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u>  <u>MINUTES</u>  <u>1 WEEK</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>331X II</u>			<u>PROBABLE GN @ SEPTICEMIA &amp; SHOCK</u> <u>15 hours</u>		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>                    </u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>                    </u>	
22. I certify that (I) (this hospital) attended the deceased from <u>8/11</u> 19 <u>65</u> to <u>8/17</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8/17</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John G. Frizzera M.D.</u> DEGREE				23B. DATE SIGNED <u>AUG 17, 1968</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOHN E. FRIZZERA M.D.</u> DEGREE				23D. ADDRESS <u>SOUTH BALTIMORE GENERAL HOSP</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/20/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>CEDAR HILL CEMETERY</u>	
				24D. LOCATION (City, town, or county) (State) <u>GLEN BURNIE, MARYLAND</u>	
25A. DATE RECEIVED <u>AUG 20 1968</u>		25B. NAME OF REGISTRAR <u>John E. Frizzera</u>		25C. FUNERAL DIRECTOR <u>McCallum F.H. 130 E. Fort Ave.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">68- 8485</span>	
68- 8485				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HERBERT C. HUTSON		8/17/68 9 45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL			A. STATE MARYLAND		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER 8500 JAMES AVENUE		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/14/95	9. AGE (In years, lost birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lead Burner		10B. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John T. Hutson		14. MOTHER'S MAIDEN NAME Rachel Simpson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 226-03-1429		17. INFORMANT Rachel Hutson	
18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: pulmonary edema (B) metastatic ca (liver, lungs, ?) (C) colon (splenic flexure) carcinoma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days 4 yrs.	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 19C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/16 1968 to 8/17 1968, that (I) (we) last saw the deceased alive on 8/17 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Karl Rosenfeld, M.D.				23B. DATE SIGNED 8/17/68	
23C. PHYSICIAN'S NAME (Type) KARL ROSENFELD, M.D.				23D. ADDRESS Sinai Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-21-68		24C. NAME OF CEMETERY or CREMATORY Medowridge Cemetery	
24D. LOCATION Dorsey Howard Co-Md		24E. STATE MD			
25A. DATE REC'D BY HEALTH DEPT. AUG 20 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Garfield Evans & Son	
				ADDRESS 8802 Harford Rd	



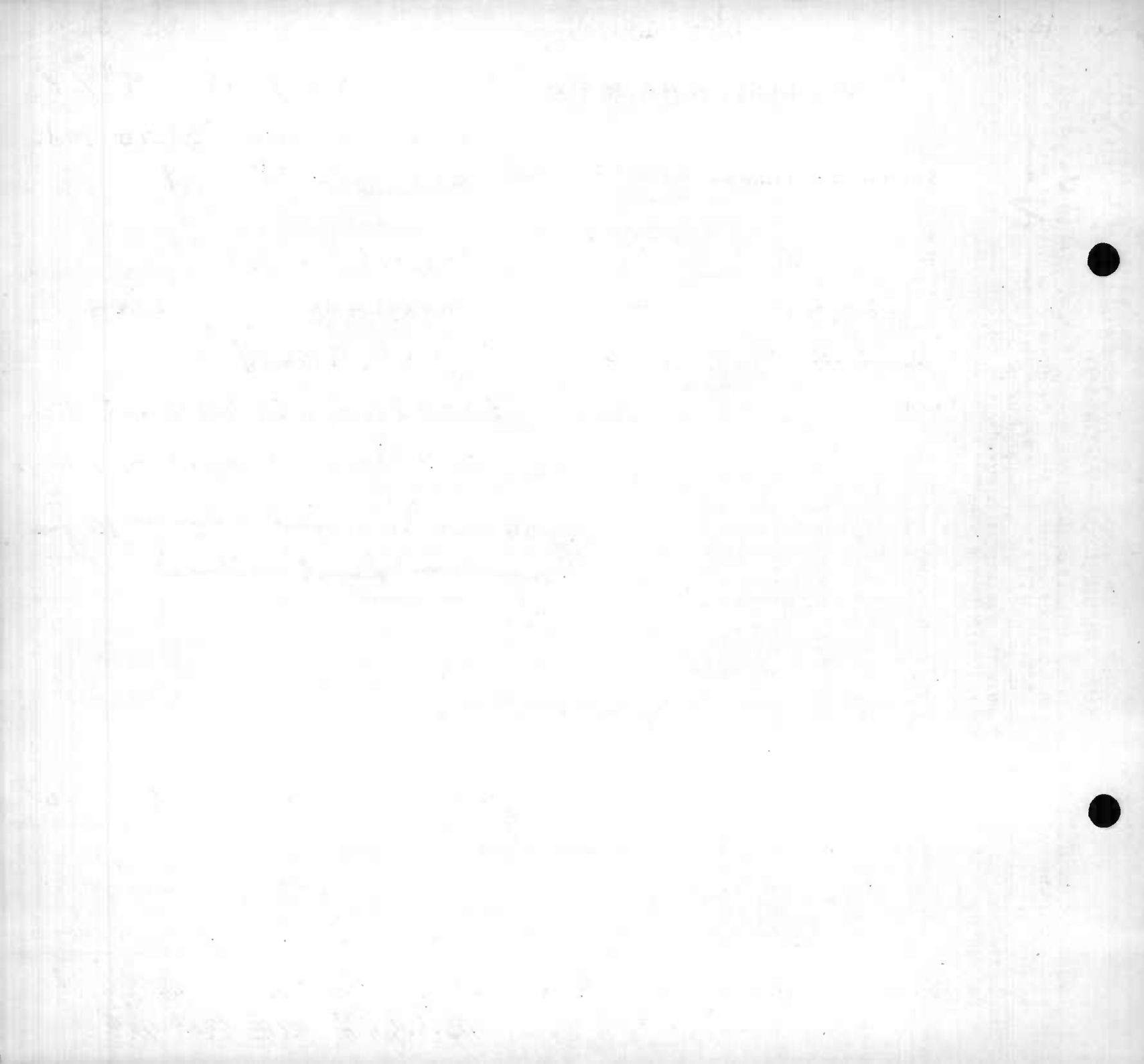
FUNERAL DIRECTOR: IMPORTANT

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# BALTIMORE CITY HEALTH DEPARTMENT 68- 8486 CERTIFICATE OF DEATH

REG. NO. 68- 8486

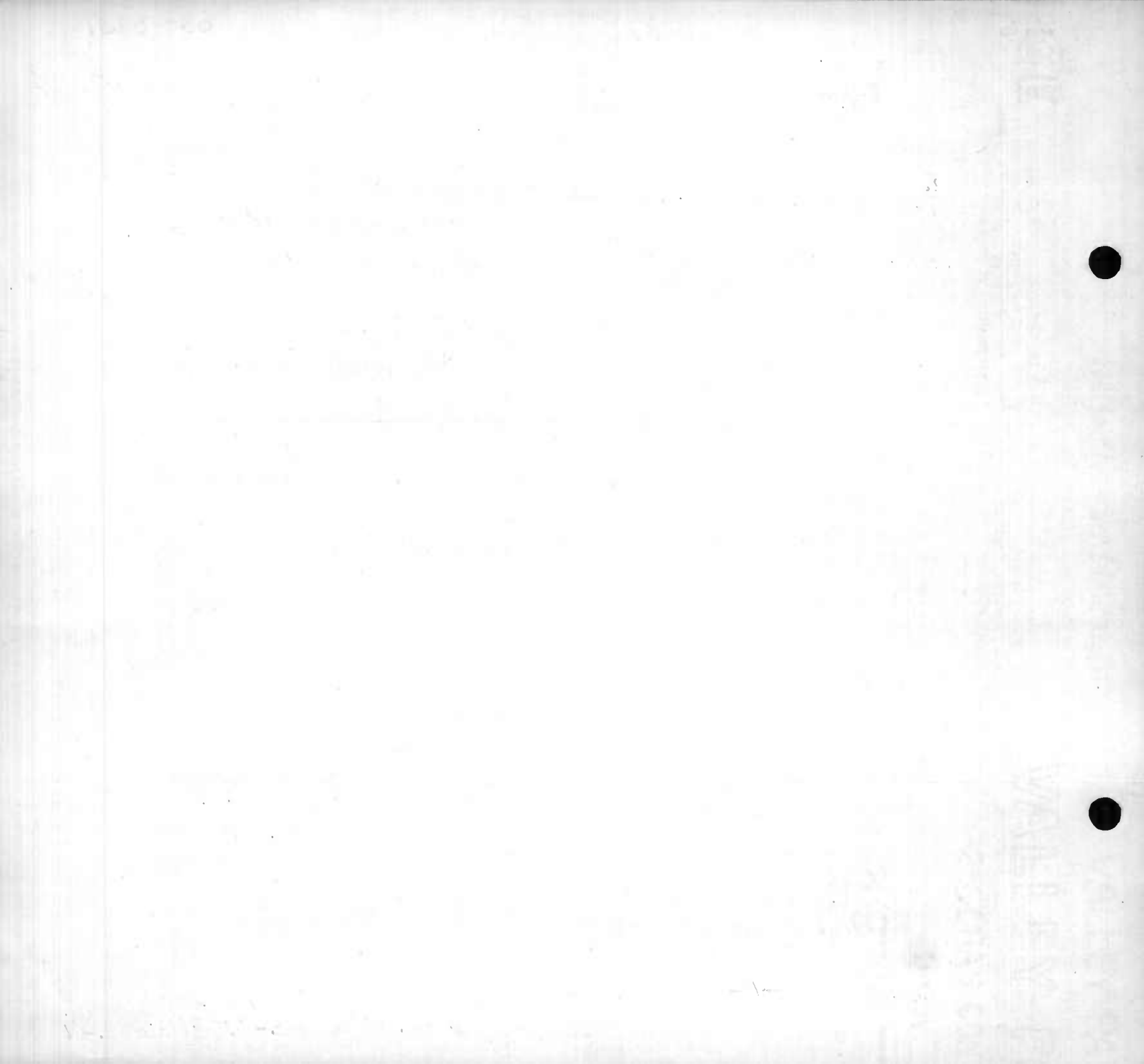
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WILLIAMS, MARNETTE</b>		2. DATE AND HOUR OF DEATH <b>8/17/68 940 P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>BALTO</b> B. COUNTY <b>md.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SOUTH BALTIMORE GENERAL HOSP.</b> <b>43</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE MD</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F.</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		8. DATE OF BIRTH <b>1-31-01</b>	
13. FATHER'S NAME <b>CARNEY FORREST</b>		14. MOTHER'S MAIDEN NAME <b>IDA RIDGELL</b>		9. AGE (In years last birthday) <b>67</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
18. <b>4/20/01</b>		CAUSE OF DEATH		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE <b>Acute Myocardial Infarction 3 days</b> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertensive Cardiovascular disease 10 yrs.</b> (C) <b>Coronary heart failure</b>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Aug 15</b> 19 <b>68</b> to <b>Aug 19</b> 19 <b>68</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>Aug 19</b> 19 <b>68</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(We)</b> did (did not) view the body after death.					
23A. SIGNATURE <b>Sang Yoon Rhim</b>				23B. DATE SIGNED <b>Aug 18 68</b>	
23C. PHYSICIAN'S NAME (Type) <b>SANG YOON RHIM MD</b>				23D. ADDRESS <b>South Baltimore General Hosp</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/22/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Geo Burner Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 20 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>McCallister</b>			
25D. ADDRESS <b>130 E. Fort Ave.</b>					



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68- 8487</b>	
<div style="display: flex; justify-content: space-between;"> <span><b>5-1261</b></span> <span><b>68- 8487</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<b>GERDA M. SPIEKER</b>		<b>8/15/68</b> <b>1 12 35 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University of Maryland Hospital</b>			A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <b>3025 OVERLAND AVE</b>		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
<b>Female</b>	<b>White</b>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>3/19/21</b>	<b>47</b>	<b>U.S.A.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<b>H/W</b>				<b>GERMANY</b>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
<b>PAUL GOEHLERT</b>			<b>MARGARET BOERNER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				<b>chant</b>	
18. <b>157191</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Intestinal obstruction</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Metastatic Gastric Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
<b>157191 II</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<b>6/68</b>		<b>Intest. obstruction</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <b>8/14</b> 19 <b>68</b> to <b>8/15</b> 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>8/15</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<b>Lloyd B. Mangel MD</b>					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
<b>Lloyd B. Mangel MD</b>		<b>Univ. of Md Hosp</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<b>Burial</b>		<b>8-19-68</b>		<b>Parkwood Cemetery</b>	
				24D. LOCATION (City, town, or county) (State)	
				<b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<b>AUG 20 1968</b>		<b>Robert E. Schuber</b>		<b>Chas. C. Miller Inc. - 6415 Belair Rd. - 21206</b>	



W-423

68- 8488 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8488

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ALEXANDER WRIGHT</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input checked="" type="checkbox"/> <b>August 16, 1968</b> 3:00 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2205 Linden Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 16, 1968</b> 6:40 P.M.	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>2-1-1920</b>		10. AGE (In years lost birth day) <b>48</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Oak City, N.C.</b>		12. CITIZEN OF <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Cement Finisher</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, near unknown) (If yes, give war or dates of service) <b>Yes</b>		17. SOCIAL SECURITY NO. <b>219-07-0618</b>	
15. MOTHER'S MAIDEN NAME <b>Ella Wright</b>		18. INFORMANT <b>Mrs. Charlotte Scott</b>	
19. <b>3-71.81 + 011.9</b>		CAUSE OF DEATH <b>Fatty Alteration of the Liver</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>3-81.0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Pulmonary Tuberculosis</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>8/17/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-21-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Nat'l Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 20 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens St.</b>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

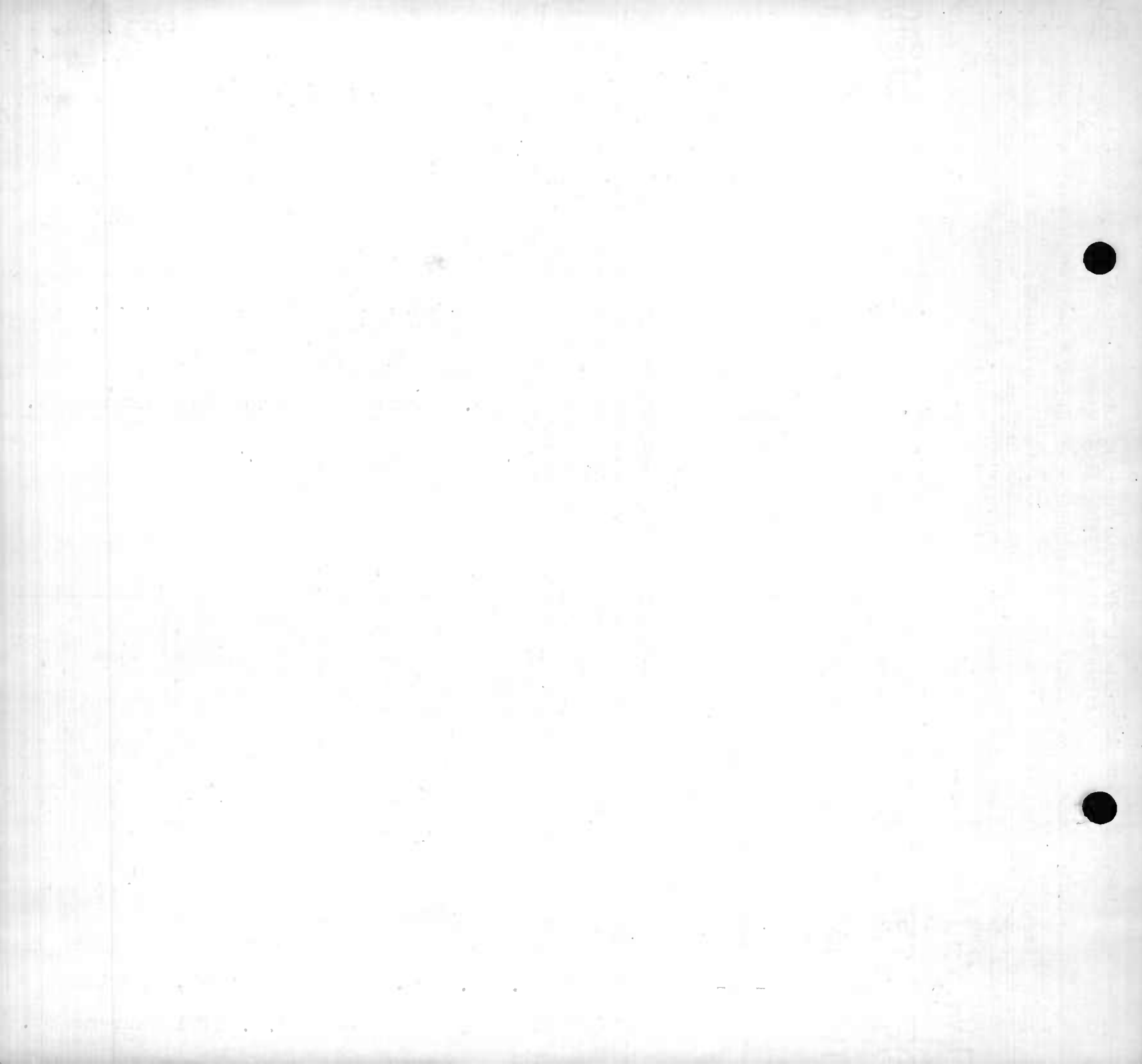
68- 8489

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 8489

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BERTHA V. HUDSON</b>		2. DATE AND HOUR OF DEATH <b>8/16/68 10<sup>30</sup> P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 THE JOHNS HOPKINS HOSPITAL</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? <b>14-02</b>
			E. STREET AND NUMBER <b>565 LAURENS STREET 21217</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>2-25-89</b>	9. AGE (In years lost birthday) <b>79</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Marley, Maryland</b>	
13. FATHER'S NAME <b>THOMAS MATTHEWS</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Robert Lee Hudson</b>
			ADDRESS <b>565 Laurens St.</b>		
18. <b>3-74.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CARDIAC ARREST</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>SEPSIS</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>COMMON BILE DUCT STONE</b>			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>COMMON BILE DUCT STONE</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>584 X II</b>					
19A. DATE OF OPERATION <b>8/16/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>COMMON BILE DUCT STONE</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/16/68</b> to <b>8/16/68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Brent L. Horsley, MD</b>				23B. DATE SIGNED <b>8/16/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>BRENT L. HORSLEY, MD</b>		23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL 601 N. BROADWAY, BALTIMORE MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-21-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Hall's Meth. Ch. Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Marley Neck, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 20 1968</b>			
25B. NAME OF REGISTRAR <b>Robert L. Hudson</b>		25C. FUNERAL DIRECTOR <b>MORTON &amp; BETT F.H.</b>			
ADDRESS <b>1701 Laurens St.</b>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

## 68- 8490 CERTIFICATE OF DEATH

REG. NO. 68- 8490

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JAMES TILLAGE</b>		2. DATE AND HOUR OF DEATH <b>August 16, 1968 10:30 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND.</b> B. COUNTY		C. CITY OR TOWN <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY OF MARYLAND HOSPITAL</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>21216 2725 HARLEM AVE</b>	
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-8-10</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRODUCTION FOREMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Va., Matthews</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>James Tillage</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Tillage</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-14-3642</b>		17. INFORMANT <b>Mrs. Nellie Tillage</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>331X II</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Possible Renal failure</b> (B) C.V. A. (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 days</b>	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21F. HOW DID INJURY OCCUR?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21D. TIME OF INJURY (APPROX.)		22. I certify that (I) (this hospital) attended the deceased from <b>7-15</b> 19 <b>68</b> to <b>8-16</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8-16</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>A. Srikumol</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>8-16-68.</b>	
23C. PHYSICIAN'S NAME (Type) <b>ANANTA SRIKUMOL MD.</b>		23D. ADDRESS <b>University Hospital of Maryland, Balt. Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-20-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>	
24D. LOCATION <b>Baltimore, Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 20 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>	
25C. FUNERAL DIRECTOR <b>Dyett F. H.</b>		25D. ADDRESS <b>1701 Laurens</b>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68- 8491

BIRTH NO.		68- 8491		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 8491	
1. NAME OF DECEASED (Type or Print) <b>WILKINS, Sherman</b>				2. DATE AND HOUR OF DEATH <b>18 Aug 68 655P</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Balt</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Fayette Convalescent Home</b>				C. CITY OR TOWN <b>Balt</b>		D. INSIDE OF HOSPITAL? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <b>422 Mosher St 21217</b>			
5. SEX <b>Male</b>	6. RACE <b>Col</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>27 Feb 02</b>		9. AGE (In years last birthday) <b>66</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>contractor</b>				11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Sam Wilkins</b>				14. MOTHER'S MAIDEN NAME <b>Jelden</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>705 123767A</b>		17. INFORMANT <b>Mrs Virginia</b>		ADDRESS <b>3034 Woodson Ave</b>	
18. <b>1539 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Branchopneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cancer (enteric)</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Branchopneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2d</b>	
19. <b>1539 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>osteomyelitis/abscess (Brain synd.)/CHF</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>enable to state</b>		(C) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>13 Aug 1968</b> to <b>18 Aug 1968</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>18 Aug 1968</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>J. Hulla</b> M.D.				23B. DATE SIGNED <b>18 Aug 68</b>		23C. PHYSICIAN'S NAME (Type) <b>J. Hulla</b> M.D.	
23D. ADDRESS <b>2214 E Fayette St 21231</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			
24B. DATE <b>8/22/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Robinson Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 20 1968</b>	
25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>Robert E. Johnson</b>		25D. ADDRESS <b>1304 N. CENTRAL AVE</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8492 CERTIFICATE OF DEATH

REG. NO. 68- 8492

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Anna Katherine Bickel</i>		2. DATE AND HOUR OF DEATH <i>August 19, 1968</i>   <i>9</i>   <i>A</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>00 146 S. East Avenue</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>146 S. East Avenue</i>		9. AGE (In years last birthday) <i>82</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug. 9, 1886</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Charles Paulus</i>		14. MOTHER'S MAIDEN NAME <i>Frieda Putche</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Henry F. Bickel 146 S. East Ave. Balto.</i>	
18. <i>431914180X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebrovascular hemorrhage</i> (B) <i>Generalized arteriosclerosis</i> (C) <i>Cancer of the cervix</i>			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>331X II</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>this hospital</del> attended the deceased from <i>Aug 18, 1968</i> to <i>Aug 19, 1968</i> , that (I) <del>was</del> lost saw the deceased alive on <i>August 18, 1968</i> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>not</del> view the body after death.					
23A. SIGNATURE <i>Melito M. Torres, M.D.</i>				23B. DATE SIGNED <i>8-19-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>MELITO M. TORRES, M.D.</i>		23D. ADDRESS <i>441 S. ELLWOOD AVE. 21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/22/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 20 1968</i>			
25B. NAME OF REGISTRAR <i>John A. Moran, Inc.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>3000 E. Balto. St.</i>			

Continued from

Continued from

Continued from

Aug 17

Aug 18

Aug 19

Aug 20

8-19-17

MELITO M. TORRES, MD 441 S. GLENN AVE 21224

68- 8493

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 8493

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH J. MARCINKO

2. DATE AND HOUR OF DEATH

8-14-68

12.45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

PENNSYLVANIA

V-35

C. CITY OR TOWN

UNIONTOWN

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

79 ELM AVENUE

15401

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

4-3-04

9. AGE (In years  
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Miner

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

York Penn Pa

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

VALENT MARCINKO

14. MOTHER'S MAIDEN NAME

VERONICA PALITSCHO

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

201-01-9548

17. INFORMANT

Nancy Fur. Home Uniontown Pa

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

2 weeks

2 weeks

"

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐  
WorkNot While ☐  
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Aug 13 19 68 to Aug 14 19 68.  
that (I) (we) last saw the deceased alive on Aug 14 19 68 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S  
NAME (Type)

L. ROSOFF

DEGREE

Attending ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

Aug 14, 1968

23D. ADDRESS

601 N. BROADWAY - JHH

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

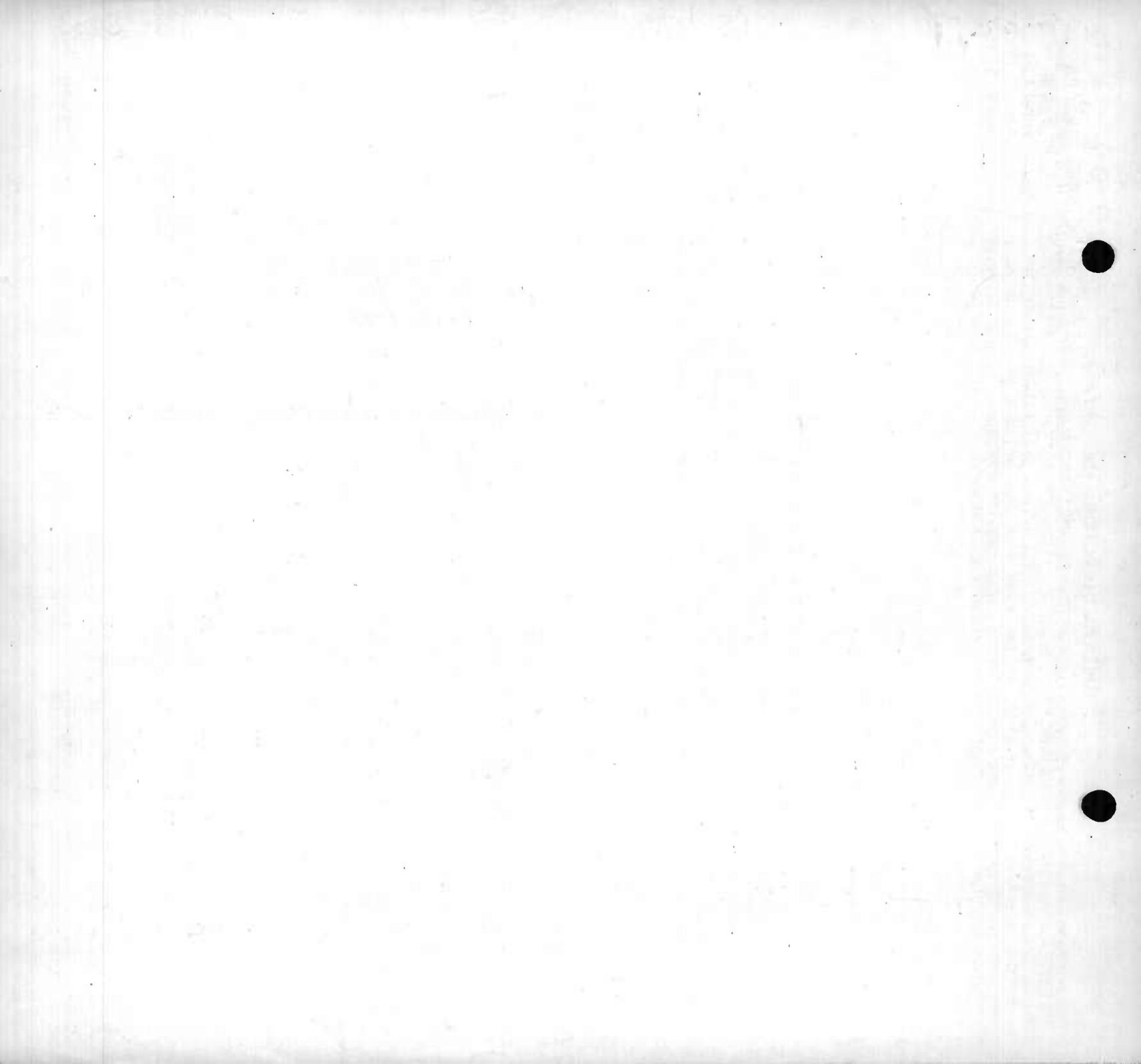
25C. FUNERAL DIRECTOR

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

33-0794  
JOSEPH J. MARCINKO



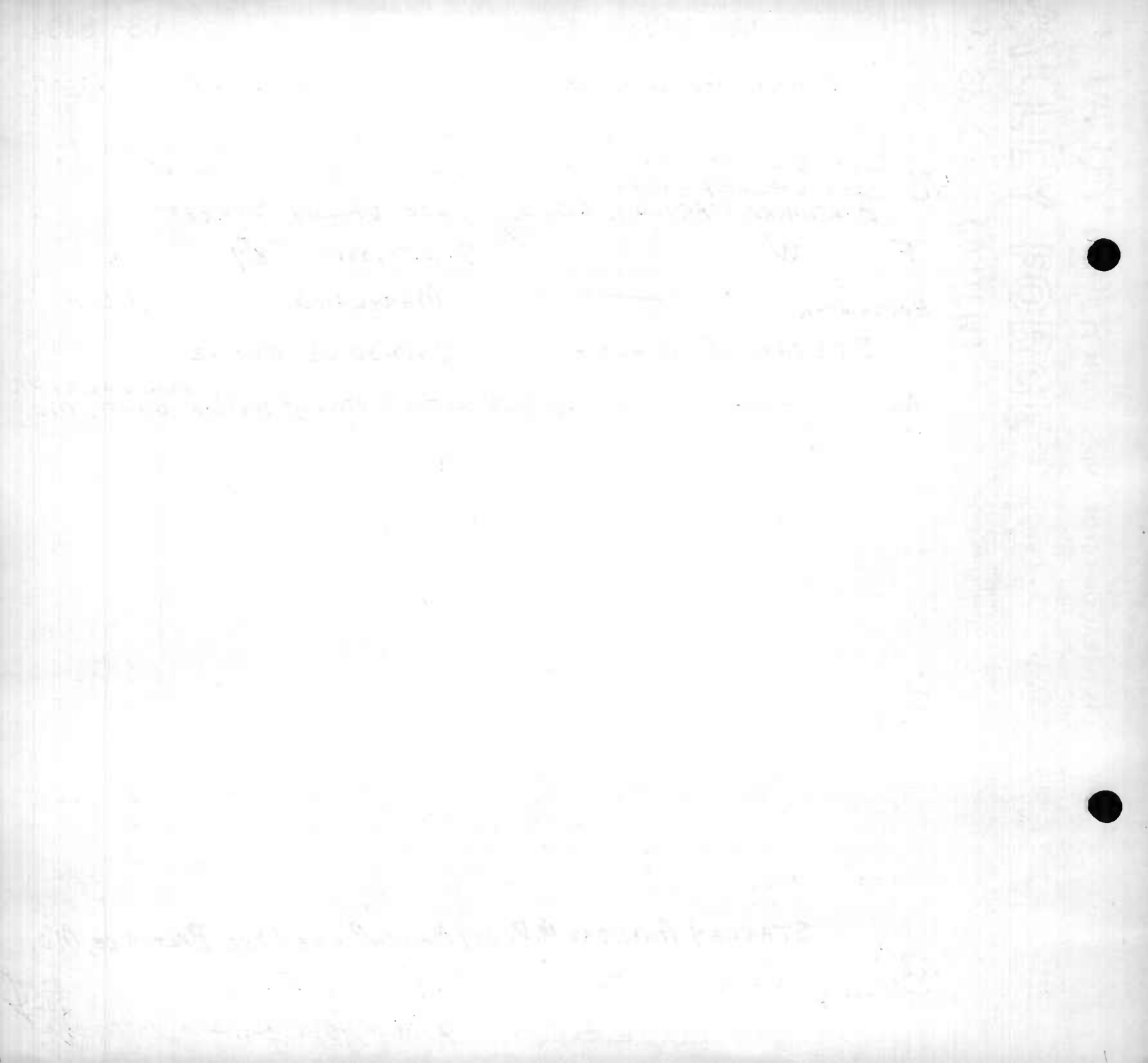
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8494 BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68- 8494

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARY A. WALSH</b>		2. DATE AND HOUR OF DEATH <b>8-16-68 6:00P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 LITTLE SISTERS OF THE POOR 1200 VALLEY STREET BALTIMORE, MARYLAND 21202</b>		E. STREET AND NUMBER <b>1200 VALLEY STREET</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-25-1881</b>	9. AGE (In years - last birthday) <b>87</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>STEPHEN J. WALSH</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE ROCHE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-48-8355</b>		17. INFORMANT <b>Little Sisters of the Poor</b> ADDRESS <b>1200 VALLEY ST. BALT., MD.</b>	
18. <b>410.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Death massive myo</b> <b>cardiac in forebrain</b> <b>Angina pectoris</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>420.1 II</b>					
19A. DATE OF OPERATION <b>D</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1968 to Aug. 16 1968</b> , that (I) (we) lost saw the deceased alive on <b>Aug 16 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Stanley Ankudas</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>8.19.68</b>	
23C. PHYSICIAN'S NAME (Type) <b>STANLEY ANKUDAS, M.D.</b>		23D. ADDRESS <b>1101 MALDEN CHOICE LANE, BALTIMORE, MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial 8/29/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cathedral Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 20 1968</b>		25B. NAME OF REGISTRAR <b>Philip Herwig</b>		25C. FUNERAL DIRECTOR <b>Philip Herwig</b>	
				ADDRESS <b>2024 Orleans St</b>	



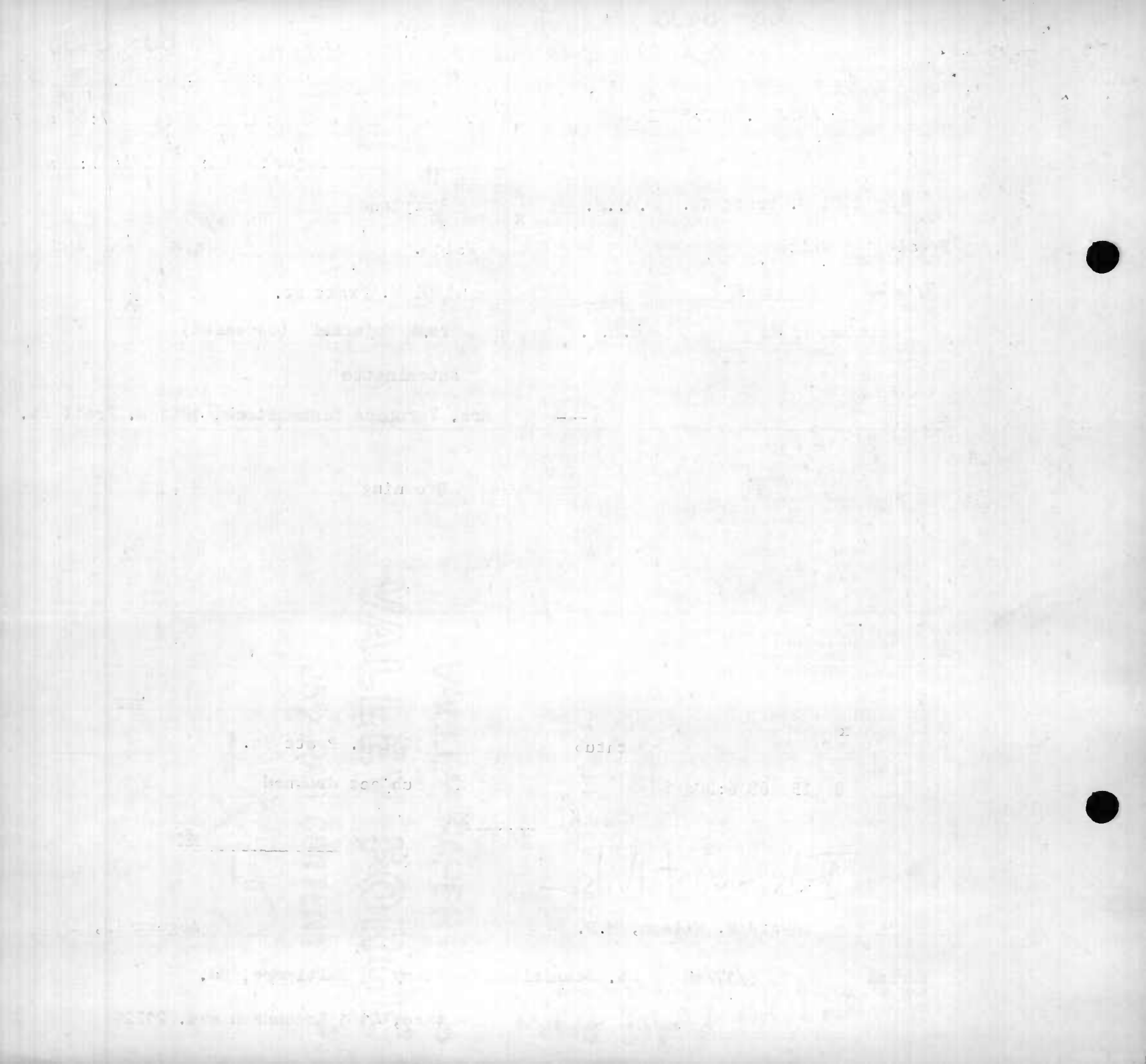
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 8495

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>ANNA E. BOJARSKI</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>8 15 68 7:30 a.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1801 W. Pratt St. D.O...A.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 15 1968 7:30a.m.</b>	
6. SEX <b>Female</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>7/6/14</b>		10. AGE (In years lost birthday) <b>54</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>---</b>	
18. INFORMANT <b>Mrs. Veronica Blumenstock, 1801 W. Pratt St.</b>		ADDRESS <b>1801 W. Pratt St.</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>E984X</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Drowning</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION <b>E929.0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>YES</b>		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Bathtub</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1801 W. Pratt St.</b>	
22D. TIME OF INJURY (APPROX.) <b>8 15 68 6:30a.m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>Subject drowned</b>		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/17/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>St. Stanislaus Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 20 1968</b>		25B. NAME OF REGISTRAR <b>Robert L. Farkner</b>	
25C. FUNERAL DIRECTOR <b>Witzko, 4101 Edmondson ave. 21229</b>		ADDRESS	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 8496

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Edith Thornton</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>8 15 68</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 211 W 27<sup>th</sup> St</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>8 17 68 1100 A</b> M.	
6. SEX <b>Female</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>Can</b>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Nov. 5, 1892</b>		D. INSIDE CITY LIMITS? <b>12-07</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birthday) <b>75</b>		E. STREET AND NUMBER <b>211 W 27<sup>th</sup> St</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Late George Kerns</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
14B. KIND OF BUSINESS OR INDUSTRY <b>---</b>		15. MOTHER'S MAIDEN NAME <b>---</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>---</b>	
18. INFORMANT <b>Mrs. Norman Downing Balto., Md. 21229</b>		ADDRESS <b>811 N. Chapelgate</b>	
19. <b>E 880X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CRANIO Cerebral injury</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION <b>E 900.0</b>		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>211 W 27<sup>th</sup> St</b>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>8 15 68</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>supposedly fell down steps</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. EXAMINER'S NAME (Type) <b>Werner U. Spitz</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>8-18-68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/20/68</b>	
24C. NAME of CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Balto. Co., Md.</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 20 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Sankara</b>	
25C. FUNERAL DIRECTOR <b>Witzke Fun. Dir., 4101 Edmondson ave.</b>		ADDRESS <b>21229</b>	

Griffin & Co. Portland, Me.

8 12 63

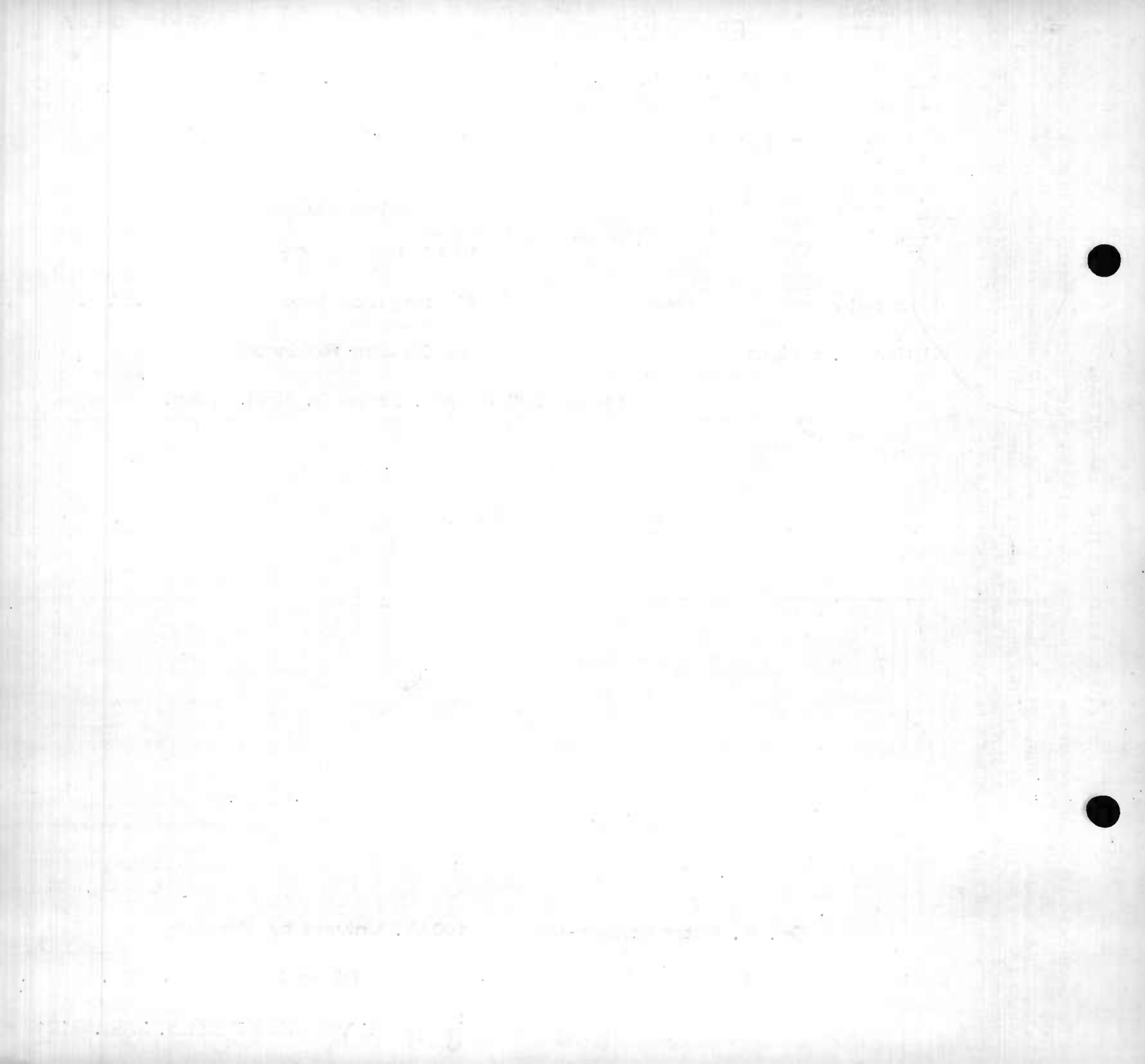
James H. Smith  
Portland, Me.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8497 CERTIFICATE OF DEATH

REG. NO. 68- 8497

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Lillian Virginia Naylor		Aug. 19, 1968 3.10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 4206 Roland Avenue				A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4206 Roland Avenue	
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-31-1888	9. AGE (In years last birthday) 79	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Easton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William T. Wright			14. MOTHER'S MAIDEN NAME Emily Jane Robinson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-03-6703-B	17. INFORMANT ADDRESS Mr. Frank D. Naylor, Sr. Same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 412.31 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Cardiac arrest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: arteriosclerotic H.D. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immed 10 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.0 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 19 58 to 8-19-19 68, that (I) (we) lost saw the deceased alive on July 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. K. Peter vanBerkum				23B. DATE SIGNED 8-20-68	
23C. PHYSICIAN'S NAME (Type) Dr. K. Peter vanBerkum				23D. ADDRESS 100 W. University Parkway	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-21-68		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	
24D. LOCATION (City, town, or county) (State) Pikesville, Balto., Co., Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 20 1968			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS Henry W. Jenkins & Sons Co., 4905 York Road Balto., Md. 21212			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 8498

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Mildred Keegan</b>		2. DATE AND HOUR OF DEATH <b>8-19-68 14:00 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2715 N. Charles St.</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 Union Memorial Hosp.</b>			(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-14-92</b>	9. AGE (In years lost Withdow) <b>76</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>Canada</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>Joseph Guy</b>		14. MOTHER'S MAIDEN NAME <b>Susan Pocket</b>	
15. Was Deceased ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-28-1920A</b>		17. INFORMANT <b>WILLIAM KEEGAN</b>	
18. <b>250.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Bronchopneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 day</b>		ADDRESS <b>6028 BLACK FRIARS CIRCLE 21228</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pulmonary edema</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Diabetes mellitus</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>260X II</b>		<b>Arteriosclerotic Heart Disease</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>44</b> (this hospital) attended the deceased from <b>8-18</b> 19 <b>68</b> to <b>8-19</b> 19 <b>68</b> , that (i) <del>was</del> last saw the deceased alive on <b>8-19</b> 19 <b>68</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) (did not) view the body after death.					
23A. SIGNATURE <b>Stephen Goldberg</b> DEGREE				23B. DATE SIGNED <b>8-19-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. STEPHEN GOLDBERGER</b> DEGREE				23D. ADDRESS <b>2511 D. Steele Road 21209</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/21/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	
24D. LOCATION <b>Baltimore, Md.</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 20 1968</b>		25B. NAME OF REGISTRAR <b>Clara E. Sullivan</b>		25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>	

2012 12 12

9-11-12 12

Super Rocket  
Canada

Joseph Guy  
housewife  
Female White

African x female Newt Brown  
Diabetes Mellitus

103

8-12-12

8-12-12

8-12-12

Joseph Guy

103

8-12-12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 8499 CERTIFICATE OF DEATH

REG. NO. 68- 8499

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Mr. Charles H. Dasch</b>		2. DATE AND HOUR OF DEATH <b>8/19/68 1:30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Church Home and Hospital</b> <b>35</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>W.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AMERICAN OIL CO.</b>		8. DATE OF BIRTH <b>5.20.90</b> 9. AGE (In years last birthday) <b>78</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>CHARLES HENRY DASCH</b>	
14. MOTHER'S MAIDEN NAME <b>Emiline Reess</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-018404A</b>	
17. INFORMANT <b>MRS. MARY E. DASCH</b>		ADDRESS <b>(SAME)</b>		18. <b>4-4-9-1</b> CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Peripheral Circulatory failure</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Aortic Aneurysm with</b>			
(C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>451X II</b>					
19A. DATE OF OPERATION <b>6</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b> <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-19-68</b> to <b>8-19-68</b> , that (I) (we) lost saw the deceased alive on <b>8-19-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>A. E. SUBONG</b>				23B. DATE SIGNED <b>8-19-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. A. E. SUBONG, JR.</b>				23D. ADDRESS <b>Church Home &amp; Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/22/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood</b>	
24D. LOCATION <b>Balto. Co.</b>		24E. (City, town, or county)		24F. (State) <b>Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 20 1968</b>		25B. NAME OF REGISTRAR <b>Robert L. Jenkins</b>		25C. FUNERAL DIRECTOR <b>H.B. Jenkins &amp; Sons Co.</b>	
25D. ADDRESS <b>Balto. 12, Md.</b>		25E. ADDRESS <b>4905 York Rd.</b>			

Dr. J. C. SUGGESTION: Change from 100 to 1000

8-10-10

2-11-10 2-11-10 2-11-10

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 8500 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 68- 8500

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Andrew E. Wright</i>		2. DATE AND HOUR OF DEATH <i>August 18, 1968.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY		5. SEX <i>Male</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>44 Union Memorial Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>4910 Harford Road</i>		6. DATE OF BIRTH <i>6/24/98</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <i>70</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Baker</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Edward Wright</i>		14. MOTHER'S MAIDEN NAME <i>Wilhelmina ?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. Michael F. Delea, Jr.</i>	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Myocardial Infarction</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		19. DATE OF OPERATION <i>4-20-1 II</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Branchial ectasia, Eustachian</i>		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>8-9</i> <i>1968</i> to <i>8-18</i> <i>1968</i> , that (I) (we) last saw the deceased alive on <i>8-10</i> <i>1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <i>Sebastian Russo</i>		23B. DATE SIGNED <i>8/18/68</i>		23C. PHYSICIAN'S NAME (Type) <i>Sebastian Russo</i>	
23D. ADDRESS <i>5017 Harford Rd</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/21/68</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Parkwood</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT <i>AUG 20 1968</i>	
25B. NAME OF REGISTRAR <i>Robert E. Stash...</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc.</i>		ADDRESS <i>Balto. Md. 21214</i>	

